

# Long-Term Care Litigation

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## Report Card on Palliative Care

**R**eleased November 18, 2002, *Last Acts'* state-by-state analysis, "Means to a Better End: A Report on Dying in America Today," sets out statistics of the availability and use of good end-of-life care. The report also calls for specific action steps to strengthen care for dying Americans. Access the full report online at [www.lastacts.org](http://www.lastacts.org). An interactive special report on *Means to a Better End*, including research findings, is available on The Robert Wood Johnson Foundation Web site, [www.rwjf.org/special/betterend](http://www.rwjf.org/special/betterend).

According to the report, America does only a mediocre job of caring for its most seriously ill and dying patients. The nation's first state-by-state "report card" on end-of-life care grades all 50 states and the District of Columbia from A to E on eight key elements of palliative care (with A being the best possible grade and E, the lowest): state advance directive laws; portion of deaths that occur at home; rate and duration of hospice use among the dying; access to hospital end of life care services; intensive care unit stays at the end of life; pain among nursing-home residents; state pain-management policies; and numbers of doctors and nurses certified in palliative care.

### State Advance Directive Policies

Some states' laws include confusing language or create bureaucratic hurdles that make it difficult for citizens to express their preferences or to designate appropriate surrogate decision-makers. States performed best in this category, which measured the extent to which state advance-care directive laws were clear, comprehensive, and easy to use. Seven states received an A, and twelve states rated a B. Most states (18)

received a C. Twenty states recommended that people draw up a single, comprehensive advance directive. Thirty-five states did not require that mandatory forms or language be used for advance directives. Advocates promote this strategy because it allows people to state their wishes in their own way.

### Location of Death

Although research shows that 70 percent of Americans would prefer to be at home with loved ones in their final days, only about 25 percent die at home. Where people die—in a hospital, a nursing home, a hospice, or at home—depends on the state or community where they live and the health care resources available there. Research has shown that these factors outweigh patient preferences. The top grade was reserved for states where more than 60 percent of deaths occurred at home. No state earned an A or a B in this category. Most scored a D; in these states, between 15 and 30 percent of deaths occurred at home.

### Hospice Care Use

Hospice care is a "gold standard" for end-of-life care. However, hospice is not widely used in most states. The top grade in this category was reserved for states where more than 50 percent of elderly people used hospice in their last year of life. No state scored an A. The only B was given to Arizona, where hospice use was 42 percent. Most states ranked a D, with between only 12 to 25 percent of all elderly deaths including a hospice stay.

### Hospice Length of Stay

The average length of stay in hospice has dropped to well below the 60 days considered necessary for people

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to get maximum benefit. In fact, dying patients commonly have the support of hospice care for less than a week. An A was reserved for states where the median hospice length of stay was 60 days. No state achieved an A or a B. Most received a D, with median length of stay between 15 and 30 days.

**Hospital End-of-Life Care Services**

Though the number of organized palliative care programs in hospitals is increasing, such programs are not yet the norm. Nor do a sufficient number of hospitals offer pain management programs and hospice services. Each service was considered separately. States were placed into one of five groups, with the better states having the most hospitals that offer formal end-of-life care services. No state earned an A; most states received a C. Nationally, about 14 percent of hospitals offered a formal palliative care program; 23 percent offered hospice care and 42 percent had pain-management programs.

**Intensive Care Units (ICUs) At the End of Life**

Nationwide, 28 percent of Medicare patients who die are treated in ICUs in their last six months of life. The rate varies widely, even within individual states. Patients in ICUs typically are subjected to heavy use of technology. This may be at the expense of attention to comfort or against expressed treatment preferences. This measure was graded on a curve. The higher-ranking states

had lower percentages of Medicare patients who spent a week or more in the ICU in their last six months of life. States ranged between 3 and 17 percent. Five states where the ICU rate was under 6 percent received an A. Most states rated a C; between 8 and 12 percent of Medicare patients stayed a week or longer in the ICU at the end of life.

**Persistent Pain Among Nursing Home Residents**

Nearly half of the 1.6 million Americans living in nursing homes have persistent pain that is not noticed and not adequately treated. In this category, an A was reserved for states where fewer than 25 percent of nursing home residents reported being in pain for at least two months without relief. No state received an A. Most scored a C; between 35 to 45 percent of nursing-home residents in these states were in persistent pain.

**State Pain-Management Policies**

All states have laws addressing the use of controlled substances. Some are effective, but others create formidable barriers to good pain management. High-ranking states in this category had pain laws that define good medical practice in pain management and relieve physicians' fears of being penalized for aggressively treating pain. Seven states received an A and nine states earned a B. Most states fell in the C and D range. Twenty-four states had pain-

*continued on page 15* ►

**Opinion Poll Shows Desire for Improved Palliative Care**

Along with the national report card on end-of-life care, *Last Acts* simultaneously released a public opinion poll showing that the majority of Americans are critical of the care dying people in this country receive. The survey found that six in 10 Americans give our current health care system a rating of only fair or lower, including a quarter who rate it as poor. Only one in 10 gives the system a rating of very good or excellent. Survey results also showed that most Americans believe improving care is important. ■

## Practice Tip

# What Plaintiff's Counsel Look for After a Fall

**P**laintiff's counsel likely will tour the location where the nursing home resident's fall is alleged to have occurred. Counsel should visit their client at the facility around the same time the incident happened, seeking insight into environmental factors, staffing levels, and/or other aspects of care that arguably support case facts to be asserted in the lawsuit complaint. This might involve visiting the client in the evening and/or on a weekend. Plaintiff's counsel may observe, among other possibilities, any of the following:

### Facility Appearance

- How did the facility appear physically?
- Are passageways free of obstacles?
- Are hallways wide enough to allow passage of two wheelchairs with ease?
- Does a wheelchair ramp offer access into and out of the facility?
- Is the facility undergoing any construction or renovation?

### Floor Surfaces

- Identify type of floor surface. For example, is it linoleum, tile, carpet, or a combination of surfaces?
- Are there slip-resistant ceramic tiles or linoleum?
- Is unglazed tile on resident bathroom floors?
- Are linoleum floors treated with anti-skid acrylic coatings?
- What was the condition of the floor surface (for example, any fluid yet to dry from recent mopping)?
- Were the floors highly polished? If yes, this may cause residents to fall.
- Are there any patterned or checkered linoleum or carpet designs? An older adult's decline in depth perception makes these surfaces

appear as elevations or depressions.

- Are there any hazardous ground surfaces? Although negotiable by functionally healthy individuals, they become major obstacles for residents with altered mobility.
- Are there slip-resistant throw rugs?
- Are carpeted edges tacked or taped down? Any curled edges or excessive wear?
- Are there deep-pile or shag carpets? Both promote tripping among older adults.
- Is there indoor-outdoor carpeting in resident bathrooms? Persons who rely on walkers may experience difficulty with a carpeted surface, as will those persons who walk with a shuffle.
- Are slip-resistant strips on the floor next to the sink and toilet used by residents? Are the slip-resistant strips in a noncontrasting color to the floor surface (to prevent easy visualization)?

### Lighting

The facility must provide “[a]dequate and comfortable lighting in all areas.” [See 42 C.F.R. § 483.15(h)(5).]

- Is there any difference between daytime and nighttime lighting? An older adult's visual capacity may be compromised when walking in low light conditions.
- What is the availability of night lights in bedrooms and bathrooms?
- Is there any excessive glare? The aging eye is sensitive to glare—for example, sunlight shining through windows and reflecting off a waxed floor or glossy tabletop. Floor glare is troublesome because it hides ground surface hazards. Glare produces visual distortion that causes the older adult to perceive the floor surface as excessively slippery. The resident alters his or her gait (as if

walking on ice) to compensate and, thus, may become unsteady and fall.

- Is there any bright light from unshielded light and fluorescent bulbs directed toward the eye?
- Are bedroom and bathroom light switch plates, lamp pull chains, lamp pull cords, and switches visually and physically accessible?
- Are light switches conveniently located by room entrance to avoid searching in the dark?

### Housekeeping and Maintenance

The facility must provide housekeeping and maintenance services necessary to “maintain a sanitary, orderly, and comfortable interior.” [See 42 C.F.R. § 483.15(h)(2).]

- Does any unmonitored housekeeping equipment present a fall hazard?
- Are cleaning agents left unattended in the hallways, common areas, or resident rooms where residents can trip over them or otherwise cause their contents to spill?
- Are any observable spills or other accidents cleaned up quickly?

### Furnishings

- Are furnishing surfaces (such as chair and toilet seats or bed mattress edges) visually distinguishable?
- Are chairs able to support safe, independent transfers?
- Are chairs or beds too low or too high, too soft, on wheels, or on uneven or slippery surfaces?
- Is there any inappropriately placed furniture?
- Is there any unstable or low-lying furniture?
- Are there any low chairs without armrest support or seat backs?
- Are any cabinets too high or too low?
- Are chairs and beds well-maintained?

## Safety Observations

“The facility must ensure that (1) [t]he resident environment remains as free of accident hazards as is possible; and (2) [e]ach resident receives adequate supervision and assistive devices to prevent accidents.” [42 C.F.R. §§ 483.25(h)(1) and (2).]

- Does the facility equip corridors with handrails [See 42 C.F.R. § 483.70(h)(3).] and place grab bars next to bathtubs, showers and toilets? Are they securely fastened? Wall mounted? At an appropriate height?
- Are handrails rounded for a solid hand grasp, color contrasted to the walls for easy visibility, and conveniently located for resident use?
- Are there any other accident prevention features? Make a list.
- Are toilet facilities designed to accommodate wheelchair-bound residents?
- Are several toilet seat heights available to provide for proper sitting height?
- Are toilet seats made of soft vinyl plastic to reduce resident risk of pelvic or hip fracture?
- If wandering is an issue, does the facility have a wander guard system? Entry/exit alarms?
- Is there a fire safety system that includes smoke and heat detectors and sprinklers?
- Is a plan posted for quick evacuation in case of fire?
- Are fire doors blocked?
- Are exits clearly marked and unobstructed?
- Are any residents ignoring facility smoking policies?
- Do potential staff members undergo a background check?

## Physical Restraint

The efficacy of physical restraints in fall prevention has never been clinically demonstrated. Interventions such as regular ambulation and other exercises that increase strength, balance, and coordination are more effective fall prevention measures.

- During the attorney’s visit, were few or no residents physically restrained?
- How many restrained residents are there?
- Was the client restrained?
- Did the client mention restraint?

## Resident Activities

“The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.” [42 C.F.R. § 483.15(f)(1).] Exercise improves a resident’s functional status and reduces the risk of

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falls and injurious falls. Physical activity may prevent the occurrence of or lessen the severity of fall-related injury by increasing bone mineral density and improving coordination, reaction time, muscle strength, and mobility. Various modalities include resistance training to increase muscle strength and exercises that improve endurance, flexibility, and balance (e.g., tai chi). All activity programs must be tailored to the individual needs of a specific resident, especially for those persons with limitations in their activities of daily living.

- Does the facility provide varied exercise activities?
- Are exercise programs tailored to resident needs by a knowledgeable exercise professional (e.g., physical therapist, occupational therapist, or physiatrist)?
- Does the home allow residents to choose the type of exercise activity

consistent with his or her interests, assessments, and plans of care? [See 42 C.F.R. § 483.15(b).]

- Are there any activity rooms or designated space for residents who can be involved in activities?
- What types of exercise activities were the residents engaged in during the visit?
- Are outdoor recreation areas (such as a lawn or garden) in use?
- Did staff encourage residents to go outside?

## Staffing

The facility “must promote care for residents in a manner and in an environment that maintains or enhances each resident’s dignity and respect[.]” [42 C.F.R. § 483.15(a).] Watch and talk to the staff for clues as to their attitudes toward their jobs and how they feel about caring for residents. The client also can supply an opinion on the staff as can the client’s family and friends, other residents, and facility volunteers. In general, defense counsel recommend that employees and administrators not discuss an incident with anyone, even amongst themselves, without counsel.

- Is there a good resident-to-staff ratio? [See 42 C.F.R. § 483.30(a).]
- Did the attorney see a physician in the facility or the resident’s attending physician? [See 42 C.F.R. § 483.40.]
- If possible, observe the employee time clock at the end of a shift. Is staff anxious to leave?
- During the attorney’s visit, did staff interact personally with residents in a friendly and respectful manner? [See 42 C.F.R. § 483.13(c).]
- Did staff members treat the residents with warmth and respect?
- Are residents treated as adults?
- Are staff members courteous to residents?
- Are residents addressed by their names?
- Did staff interact in an impersonal or brusque manner?
- Was there an effort by staff to

- meet residents' individual needs?
- Did staff encourage residents to act independently?
- Were call lights timely answered?
- Did staff answer resident questions for assistance quickly?
- Did nurse aides demonstrate the skills and techniques necessary to care for resident needs? [See 42 CFR § 483.75(f).]
- Are any specialized rehabilitation services available (such as physical or occupational therapy)? [See 42 C.F.R. § 483.45(a).] If yes,
  - Does the facility provide the required services? [See 42 C.F.R. § 483.45(a)(1).]
  - Are services supplied by an outside source? [See 42 C.F.R. § 483.45(a)(2).]
  - Do the services satisfy resident needs as prescribed?

Federal law requires that a facility honor the resident's needs and preferences "except when the health or safety of the resident or other residents would be endangered." [42 C.F.R. § 483.15(e)(1).] Consider staff awareness of the resident's...

- Toileting habits (for example, how often and when)
- Sleeping patterns (for example, whether the resident is an early bird or a night owl)

### Entry/Exit Alarms

If the fall injury was sustained because of resident wandering or elopement behavior, consider whether the facility has entry/exit alarms.

- Is there an alarm system? If yes, this triggers another set of inquiries to be answered with additional research beyond the scope of the client visit, such as the following:
  - Is the alarm working?
  - Who manufactured the alarm system?
  - What is the name of the manufacturer's representative?
  - Who is the facility's contact person with the manufacturer?
  - Are there any files regarding alarm system purchase and ser-

vicing?

- Did the manufacturer, an outside contractor, or facility personnel install the alarm system?
- Did the facility purchase support for the product from its manufacturer? If yes, how frequently does the manufacturer visit the facility?
- Did the manufacturer provide training for staff and/or nursing home administration?
- Did manufacturer instructions governing alarm use accompany purchase and/or installation?
- How does the alarm work?
- How is alarm set or reset (for example, by code or by key)?
- When is the alarm on and when is it off?
- Who is responsible for turning the alarm(s) on and off?
- What type of signal does the alarm emit?
- How loud is the sound?
- Does the alarm manufacturer maintain records as to what nursing homes use their product?
- Does the manufacturer keep records on how frequently the alarm systems are serviced?
- Did the manufacturer receive any complaints about its alarm system not functioning?
- Was the facility aware of any complaints about the alarm?

### The Client's Room

- Does the resident's room have comfortable furniture? (Falls in a nursing home often occur when a resident attempts to unsafely rise from an uncomfortable chair.)
- Is the resident's bed too high? Does the resident have a low bed that can be manually, hydraulically or electronically adjusted to promote transfer? Bed height is crucial to safe transfer.
- Is there a nonskid mat at the side of the bed and/or toilet to reduce the likelihood of slipping? (Falling onto a hard surface increases the likelihood of serious injury.)

- Does the bathroom feature securely fastened grab bars, as well as a toilet seat individually adjusted to the resident's height to reduce falls in the bathroom?
- Does the bed have siderails? If yes, are they used as a physical restraint?
- Does the client rely upon bed and/or chair alarms that sound upon resident movement?

### Client Appearance and Attitude

- Does he or she have any unusual or unexplained bruises and injuries?
- Did the resident exhibit an unsteady gait?
- Check for improper footwear. For example, although rubber crepe soles are slip resistant, they may stick to linoleum floor surfaces, causing forward balance loss and falls. High-heeled, loose fitting, or badly worn shoes as well as slippers may increase fall risk.
- Does the client use a hip protector? If yes, what is their response to this intervention?
- Does the client wear a wander guard or other elopement control device? If yes, what is his or her response to this intervention?
- Does the client use another intervention designed to prevent or reduce fall related injury while maintaining resident mobility and independence (e.g., a bike helmet)? If yes, what is his or her response to the intervention?
- Does the client use a cane, walker, or other assistive device? If yes, ascertain client knowledge about proper use of such a device and determine if it is well maintained.
- Does the client have a vision problem that may have contributed to the fall injury?
- Does the client show any signs of fear (for example, a fear of falling that leads to dependence and immobility or a hesitation to speak openly about the facility and the incident)?
- How did the incident affect the client? ■

## In Brief: News & Studies

### National Implementation of Quality Indicators Premature

**O**n November 12, 2002, the Nursing Home Quality Initiative Program launched nationwide. On November 13, the General Accounting Office (GAO) released a report calling the implementation of the quality measures premature. “CMS’s initiative to augment existing public data on nursing home quality has considerable merit, but its planned November 2002 implementation does not allow sufficient time to ensure the indicators it publishes are appropriate and useful to consumers.” The GAO recommended that CMS delay the national reporting of quality indicators to ensure the accuracy of the data on which the indicators are based. [See “Nursing Homes: Public Reporting of Quality Indicators Has Merit, but National Implementation Is Premature” (GAO-03-187, dated Oct. 31, 2002, but released Nov. 13, 2002), [www.gao.gov/new.items/d03187.pdf](http://www.gao.gov/new.items/d03187.pdf) and [www.gao.gov/highlights/d03187high.pdf](http://www.gao.gov/highlights/d03187high.pdf).]

### Resident’s Death Highlights Need for Oral Care

**I**n the nursing home population, poor oral hygiene is common, with a 50 [percent] prevalence of dental caries.” According to a recent report, the death of a 76-year old nursing home resident with Alzheimer’s disease was hastened by poor oral hygiene and tooth decay. The resident was brought to a hospital emergency room after having a cough and fever for three days. A chest x-ray revealed that he had partially swallowed a four-tooth dental bridge that had become lodged in his esophagus, leading to swelling and infection. “In all likelihood, this bridge had been aspirated several weeks prior to presentation, but because the [resident] was fed through a gastrostomy tube, no symptoms were identified prior to

esophageal perforation.” The bridge likely loosened due to cavities that rotted away the roots of the resident’s teeth. This report underscores the need for residents to receive prophylactic dental hygiene. Federal regulation (42 C.F.R. § 483.55) requires that nursing homes assist their resident’s in obtaining routine and 24-hour emergency dental care. [See John S. Oghalai, “Aspiration of a Dental Appliance in a Patient with Alzheimer Disease,” 288 JAMA 2543-44 (Nov. 27, 2002).]

### Homicide by Decubitus Ulcers

**T**he clinical literature reports recent aggressive government activity concerning the development of pressure ulcers (also known as bedsores, pressure sores, decubitus ulcers, or decubiti) by long-term care residents. Hawaii, for example, convicted an individual of manslaughter in the death of a resident at an adult residential-care home for allowing the progression of pressure ulcers without seeking medical help and for not bringing the resident to a physician for treatment. [See Vincent J. M. DiMaio & Theresa G. DiMaio, “Homicide by Decubitus Ulcers,” 23 Am. J. Forensic Med. & Pathology 1-4 (Mar. 2002).]

### Focus Regulations on Quality Care

**T**he U. S. Department of Health and Human Services (DHHS) Advisory Committee on Regulatory Reform issued its final report November 21, 2002, highlighting 255 specific recommendations for improving regulatory requirements across DHHS agencies. The panel’s final report urges a broad range of actions to reduce the potential harm to patients that may result from unnecessarily complex, confusing, and burdensome regulations. The committee’s final report is available at [www.regreform.hhs.gov](http://www.regreform.hhs.gov).

DHHS and its agencies already

have implemented 26 recommendations and are taking significant steps to address many of others to better serve patients. For example...

- In June, the Centers for Medicare & Medicaid Services launched a new effort to streamline Medicare’s paperwork requirements for home health nurses and therapists so that they can focus more on providing quality care.

- On July 1, Medicare streamlined its paperwork requirements for nurses and other clinical staff caring for Medicare beneficiaries in nursing homes. While certain longer assessments are still required, nursing homes caring for Medicare beneficiaries can now use a shorter assessment form to gather information needed to pay Medicare claims. The change cuts the time it takes to complete the assessment form from 90 minutes to 45 minutes, while continuing to collect data needed to measure quality of care in nursing homes.

### Parolees in Illinois Nursing Homes

**A**ccording to the *Chicago Tribune*, nursing home residents in dozens of facilities throughout the state are living with former prison inmates—among them 10 convicted murders and eight sex offenders—who were placed in the facilities by the Illinois Department of Corrections. [See David Heinzmann, “Ex-Inmates Sent to Live with Elderly,” *Chicago Tribune* at 1 (Nov. 24, 2002).]

### Issue Papers on Nursing Home Care

**T**he Kaiser Family Foundation has posted on its Web site two issue papers about nursing home care. “Nursing Home Staffing Standards” ([www.kff.org/content/2002/4013](http://www.kff.org/content/2002/4013)) examines current federal staffing requirements and reviews how states regulate staffing levels. “Nursing Home Quality: State Agency Survey

Funding and Performance” ([www.kff.org/content/2002/4012/](http://www.kff.org/content/2002/4012/)) describes the resources, staffing, and performance of state licensing and certification agencies based on findings from a survey of state survey agency officials.

### Elder Abuse Occurs More Often at Home

**T**he National Center on Elder Abuse released a report on November 23, 2002, that finds most incidences of elder abuse occur in the older adult’s home. Learn more at [www.elderabusecenter.org/newsletter/newsletter\\_021101.pdf](http://www.elderabusecenter.org/newsletter/newsletter_021101.pdf)

### Cancer Incidence Data

**O**n November 18, 2002, the most comprehensive federal data available on state-specific cancer incidence rates was released. “U.S. Cancer Statistics: 1999 Incidence,” produced by the Centers for Disease Control and Prevention and the National Cancer Institute in collaboration with the North American Association of Central Cancer Registries, provides state-specific and regional data for cancer cases diagnosed in 1999, the most recent year for which data are available. The report is available at [www.cdc.gov/cancer](http://www.cdc.gov/cancer) and [www.seer.cancer.gov/statistics](http://www.seer.cancer.gov/statistics).

### Landmark Study Links Pollution to Increased Health Care Use of Older Adults

**T**he largest study ever conducted linking air pollution with medical care found that better pollution control would greatly reduce medical care use and save more than a billion dollars a year in health-care spending. The study, which appears in the journal *Health Affairs* (Nov. 12, 2002), involves an analysis of millions of Medicare records and shows that air pollution significantly increases the use of medical care among older adults—even after controlling for

region, population size, education, income, racial composition, cigarette consumption, and obesity.

Estimating medical care use in 37 areas of the country with the highest levels of air pollution and 37 areas of the country with the lowest levels of air pollution, the study researchers found that, on average, respiratory admissions and use of outpatient care were nearly 20 percent higher in the most polluted areas, medical admissions were 10 percent higher, and use of inpatient care was 7 percent higher. Not surprisingly, the researchers also found that both medical-care use and air pollution increase as the population of a given area increases.

### Relationship Between Geriatric Frailty, Biology

**R**esearchers at Johns Hopkins Bayview Medical Center have found evidence of a physiologic basis for the frailty often observed in geriatric patients. Frailty exacts an enormous toll on the health and well being of older adults. Frail older adults are among the most vulnerable members of society because they are a much higher risk for falls, fractures, infections, development of disabilities, hospitalization, institutionalization, and death than their age-matched, nonfrail counterparts. Although frailty in older individuals is frequently recognized by family members and clinicians, until recently there have been few attempts to define the biology that underlies the syndrome. The Johns Hopkins study, published in the November issue of the *Archives of Internal Medicine*, is one of the first to demonstrate associations between altered physiologic systems and the geriatric syndrome of frailty.

### JAMA Issue Addresses Aging

**T**he Journal of the American Medical Association’s (JAMA) November 13 issue is devoted to

aging. Find the full text for one of the six research articles, “Effects of Cognitive Training Interventions With Older Adults,” online at <http://jama.ama-assn.org/issues/v288n18/ffull/jtw20038.html> (subscription may be required for full access to the other articles).

### States Tackle Medical Malpractice

**A** report released December 5, 2002, by the National Governors Association Center for Best Practices suggests tort reform, insurance market intervention, alternative dispute resolution, and reduced medical errors are ways that states can address the growing medical liability problem. Find the report online at [www.nga.org](http://www.nga.org).

### Report Helps Older Pennsylvanians Choose a Medicare Managed-Care Plan

**O**ne out of four Medicare beneficiaries in Pennsylvania is enrolled in a Medicare managed-care plan. Beginning December 10, 2002, Medicare beneficiaries and their families can obtain a new report, issued by the Pennsylvania Health Care Cost Containment Council (PHC4) and the Pennsylvania Department of Aging, which compares Pennsylvania’s Medicare managed-care plans, including costs, benefits, and member satisfaction. “Choosing a Medicare Managed Care Plan—A Guide for Medicare Beneficiaries” lists Medicare managed-care plans by region, giving comparisons on monthly premiums and copayments, how well each plan does on several quality measurements, descriptions of the benefits they offer, and the results of patient satisfaction surveys. The free report is available upon request by calling PHC4 at (717) 232-6787 or the Pennsylvania Department of Aging at (717) 783-1550. The report also is available online [www.state.pa.us](http://www.state.pa.us) (keyword: aging) or at [www.phc4.org](http://www.phc4.org). ■

## Regulatory Review

Retrieve regulations discussed below from the online searchable *Federal Register* database covering volumes 60 through 67 (1995 - 2002), at [www.access.gpo.gov/su\\_docs/aces/aces140.html](http://www.access.gpo.gov/su_docs/aces/aces140.html).

### Payment Rules for Hospice Care

**C**omment by January 21, 2003, concerning a proposed rule revising current regulations that govern coverage and payment for hospice care under the Medicare program. This rule would add established Medicare hospice policies, which previously have been available only in policy memoranda, to the existing regulations. These policies clarify regulations regarding the content of the certification of terminal illness and the admission to, and discharge from, hospice care. The rule also proposes adding several new paragraphs to clarify or add to existing regulations, including a paragraph that would restate the basic requirement that a “hospice may not charge a patient for services for which the patient is entitled to have payment made under Medicare” and a paragraph that would “provide that payment for routine home care and continuous home care would be made on the basis of the geographic location where the service is provided.” [See 67 Fed. Reg. 70,363 (Nov. 22, 2002).]

Hospice care is an approach to health care that recognizes that the impending death of an individual warrants a change in focus from curative care to palliative care—that is, relief of pain and other symptoms. A hospice uses an interdisciplinary approach to deliver medical, social, psychological, emotional, and spiritual services through the use of a broad spectrum of professional and other caregivers, with the goal of making the individual as physically and emotionally comfortable as possible.

### Financial Relationships Between Hospitals and Home Health Agencies

**C**omment by January 21, 2003, about a Centers for Medicare & Medicaid Services proposal to establish a process for collecting information about hospital referrals of Medicare patients to home health agencies (HHAs) and other entities with which the hospitals have a financial relationship. The agency said it “would publicize this information in an effort to increase awareness regarding the availability of Medicare-certified HHAs and other entities to service the Medicare population, and to inform beneficiaries of their freedom to choose among available Medicare-participating providers that are capable of furnishing the needed services.” [See 67 Fed. Reg. 70,373 (Nov. 22, 2002).]

### Older Americans Act

**T**he Administration on Aging (AoA) announced December 4, 2002, that it plans to submit the Second National Outcome Measures Surveys of Older Americans Act (OAA) Clients to the Office of Management and Budget for approval. The AoA will draw samples of individuals served through Area Agencies on Aging across the country for the purpose of obtaining OAA program service assessments. The surveys will cover nutrition, transportation, caregiver support, and home care, among other service categories. [See 67 Fed. Reg. 72,217 (Dec. 4, 2002).]

### Medicare Claim Appeals Procedures

**T**he Centers for Medicare and Medicaid Services (CMS) issued a proposed rule implementing changes to the Medicare claim appeals process pursuant to Section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection

Act of 2000. The statute mandates a series of structural and procedural changes to the existing appeals process, including “[t]he establishment of a uniform process for handling all Medicare Part A and Part B appeals; revised time limits for filing appeals; reduced decision-making time frames throughout all levels of the Medicare administrative appeals system; the introduction of new entities known as qualified independent contractors (QICs) to conduct reconsiderations of contractors’ initial determinations or redeterminations; and the establishment of the right to an expedited determination when an individual disagrees with a provider’s decision to discharge the individual or terminate services.” Comment on the proposed rule by January 14, 2003. [See 67 Fed. Reg. 69,311 (Nov. 15, 2002).]

### Information Collection Activities

**T**he Centers for Medicare & Medicaid Services would like to extend currently approved collections involving physician certifications/recertifications in skilled nursing facilities (67 Fed. Reg. 71,570 (Dec. 2, 2002)) and resident assessment data as described in 42 C.F.R. § 483.20 (67 Fed. Reg. 71,572 (Dec. 2, 2002)).

### 2003 Physician Fee Schedule Delayed

**T**he Centers for Medicare & Medicaid Services (CMS) is delaying publication of the physician fee schedule for calendar year 2003 due to concerns about the accuracy and completeness of data used to establish the schedule. According to CMS, “[t]he effects of the incomplete data and information that we have identified are of such a magnitude to affect significantly the rates paid under the physician fee schedule for all physicians, nonphysician

practitioners, suppliers, and providers paid physician fee schedule rates.” The agency did not advise when the fee schedule will issue. [See 67 Fed. Reg. 67,318 (Nov. 5, 2002).]

### Medicare Ambulance Payments

The Medicare program will pay 1.1 percent more for ambulance services during 2003. The increase affects the fee schedule portion and the reasonable charge/cost portion of the blended payment amount paid to ambulance providers/suppliers. [See 67 Fed. Reg. 70,442 (Nov. 22, 2002).]

### Reimbursement for Photocopying Medical Records

Comment by January 21, 2002, on a proposed rule that would increase the rate of reimbursement for expenses incurred by prospective payment system hospitals for photocopying medical records requested by Quality Improvement Organizations (QIOs), formerly known as Utilization and Quality Control Peer Review Organizations (PROs). The rate would increase from 7 cents per page to 12 cents per page. [See 67 Fed. Reg. 70,358 (Nov. 22, 2002).]

### Ambulatory Surgical Centers

The Centers for Medicare and Medicaid Services announced its decision to approve the Accreditation Association for Ambulatory Health Care’s (AAAHC) application as a national accrediting organization for ambulatory surgical centers seeking to participate in the Medicare program and to reapprove the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as an accrediting body for same, effective December 20, 2002, through December 20, 2008. [See 67 Fed. Reg. 70,439 (AAAHC) and 70,437 (JCAHO) (Nov. 22, 2002).] ■

## Risk Management

# Physical Environment of Nursing Homes: A Legal Perspective

Julie A. Braun, J.D., LL.M.

Federal regulations mandate that nursing homes be “designed, constructed, equipped, and maintained to protect the health and *safety* of residents, [facility] personnel, and the public.” [42 C.F.R. § 483.70 (emphasis added).] This article focuses on physical environmental safety as it applies to nursing home residents rather than facility staff (e.g., occupational illness and personnel injury, handling of hazardous materials and waste) and visitors.

### Hazard and Accident-Free Environment

By law, the nursing home must ensure that “(1) [t]he resident environment remains as free of accident hazards as is possible; and (2) [e]ach resident receives adequate supervision and assistance devices to prevent accidents.” [See 42 C.F.R. § 483.25(h)(1) and (2).] The facility may, for example, offer a safe, obstacle-free outdoor space

with nonpoisonous plants and a gazebo shelter for use during appropriate seasons by residents with dementia-related illnesses who exhibit wandering behavior; replace worn carpeting or loose tiles that represent a fall hazard; remove clutter from hallways; tailor bed, chair, and toilet height to resident needs; mark slippery, wet floors with appropriate signage; require ongoing inspection, repair, and maintenance of assistive equipment (e.g., canes, walkers, and wheelchairs); adjust artificial and natural lighting for suitability to the activities being conducted; and ensure acceptable levels of temperature and humidity. [See 42 C.F.R. §§ 483.15(h)(5), (6); 483.70(h)(2).]

A qualified individual should oversee development, implementation, and monitoring of the organization’s plans for a safe environment. [See Joint Commission for the Accreditation of Healthcare Organizations, 2002-2003

Comprehensive Accreditation Manual for Long Term Care, Standard EC.1.1 (2002) (hereinafter JCAHO Standard).] The nursing home should conduct risk assessment that proactively evaluates the impact of buildings, grounds, equipment (resident personal care equipment such as lifts, bed scales, and wheelchairs), occupants, and internal physical systems on resident safety; distribute, practice, enforce, and review safety policies and procedures; ensure maintenance of grounds and equipment; and routinely evaluate safety-management program objectives, scope, performance, and effectiveness. [See JCAHO Standard EC.1.1.]

In planning to keep residents safe from accidents and injury, facility staff should consider, among other possibilities, risk factors inherent in the resident population and the scope and complexity of the care provided. [See JCAHO Standard TX.2.4.]

## Safe Environment

The facility must provide a “safe, functional, sanitary, and comfortable environment for residents, staff, and the public.” [42 C.F.R. § 483.70(h)(1) (emphasis added).] This means, for instance, corridors with firmly secured handrails on each side and an effective pest control program. [See 42 C.F.R. §§ 483.70(h)(3) and (4); 483.65.]

## Educating Residents About Safety

The nursing home should educate residents and family members where appropriate about environmental and physical plant safety issues, such as fire safety and evacuation; use of nonmedical equipment, including, but not limited to, operating call lights, beds, and personal appliances; transfer techniques; personal safety and mobility; and bathroom safety. [See JCAHO Standard PF.3.9.]

## Resident Room Environment

According to federal regulation, every nursing home must provide a “safe, clean, comfortable and home-like environment.” [42 C.F.R. § 483.15(h)(1) (emphasis added).] “Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents[.]” [42 C.F.R. § 483.70(d).]

Bedrooms cannot accommodate more than four residents. [See 42 C.F.R. § 483.70(d)(1)(i).] Shared bedrooms measure at least 80 square feet per resident as compared to 100 square feet for single resident rooms. [See 42 C.F.R. § 483.70(d)(1)(ii).] Interpretive guidelines exempt bathrooms and closets from calculation of square footage. Every resident room must have direct access to an exit corridor, at least one window, and a floor at or above grade level. [See 42 C.F.R. §§ 483.70(d)(1)(iii), (vi) and (vii).]

All resident rooms must “assure full visual privacy for each resident.” [42 C.F.R. § 483.70(d)(1)(iv).] In facilities initially certified for federal reimbursement after March 31, 1992, each bed in a shared bedroom must have ceiling-suspended curtains,

which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. [See 42 C.F.R. § 483.70(d)(1)(v).]

The facility must provide each resident with a “separate bed of proper size and height for the convenience of the resident; [a] clean and comfortable mattress; [b] bedding appropriate to the weather and cli-

*The facility must provide a “safe, functional, sanitary, and comfortable environment...”*

mate; and [f]unctional furniture appropriate to the resident’s needs, and individual closet space in the resident’s bedroom with clothes racks and shelves accessible to the resident.” [See 42 C.F.R. §§ 483.70(d)(2)(i) through (iv).]

Regulations also require that the nurse’s station be able to receive resident calls through a communication system from resident rooms as well as toilet and bathing areas. [See 42 C.F.R. §§ 483.70(f)(1) and (2).] Interpretive guidelines to federal regulation allow the communication to be audible (i.e., an intercom or buzzer) or visual (i.e., a light).

## Mechanical, Electrical, and Resident Care Equipment

The facility is obligated to “maintain all essential mechanical, electrical, and [resident] care equipment in safe operating condition.” [42 C.F.R. § 483.70(c)(2) (emphasis added).] This is particularly critical for ventilator-dependent residents.

## Life Safety From Fire

### Life Safety Code of the National Fire Protection Association

Every nursing home must satisfy applicable provisions of the Life

Safety Code of the National Fire Protection Association (NFPA). [See 42 C.F.R. § 483.70(a).] These provisions do not apply in a state where the Centers for Medicare & Medicaid Services finds “that a fire and safety code imposed by state law adequately protects patients, residents, and personnel in long-term care facilities.” [42 C.F.R. § 483.70(a)(3).]

### Facility Policy and Procedure

Facility policy and procedure should incorporate regular (announced and unannounced) fire drills where personnel from all shifts in all areas of every building where residents are housed or treated participate to the extent called for in the facility fire plan. [See JCAHO Standards EC.1.5 and EC.2.9.2.]

Devise facility policy and procedure so staff possesses the knowledge and skills to perform their responsibilities when a fire alarm sounds. For example, staff should be familiar with fire-prevention and fire-response needs; evacuation routes; their specific role and responsibility when at or away from a fire’s point of origin; use and functioning of alarm systems; building evacuation procedures; location and proper use of equipment for evacuating or transporting residents to refuge during a fire; and building compartmentalization procedures for containing smoke and fire. [See JCAHO Standards EC.1.5 and EC.1.7.1.]

In addition, policy and procedure should require the institution to demonstrate and document fire alarm and detection equipment functionality (e.g., inspect portable fire extinguishers monthly and maintain at least annually); review proposed acquisitions of bedding, window draperies, furnishings, decorations, wastebaskets, and other items for fire safety; and

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## Perspectives

# Nursing Home Industry Profitable; Cries of Poverty Don't Add Up

**U.** *S. News & World Report* examined nursing home industry finances and concluded that the industry is profitable and growing, with “operators spinning a far brighter tale for Wall Street than for Capitol Hill.” In fact, “[m]any nursing homes are earning exceptionally healthy profit margins, often 20 to 30 percent.” There is no strong evidence, as the industry asserts, that Medicaid payments are dragging down profits. After analyzing hundreds of thousands of pages of nursing home financial statements, the magazine found “no relationship between a home’s profits, or the size of its losses, and the portion of its [residents] covered by Medicaid.” Many nursing home operators “report tough financial times in their official government filings” and “steer big chunks of their revenues to themselves or related businesses before they calculate the bottom line.”

Likewise, there is no evidence to support industry claims that residents are markedly sicker today. A review of “millions of [resident] evaluations from the past three years found that acuity levels [i.e., the resident’s ability to handle activities of daily life such as eating or using the toilet without assistance] have been, essentially, flat.” For instance, the percentage of bedridden residents held steady at 5 percent, residents with pressure ulcers remained level at just under 10 percent, the portion of residents with incontinence hovered just below 60 percent, and those with infections remained around 17 percent.

Asked about the *U.S. News* report, Thomas Scully, administrator of the Centers for Medicare & Medicaid Services, “agreed that the industry’s

finances are not nearly as dire as many industry executives say.” After reviewing the magazine’s findings, Nancy Ann DeParle, the agency’s administrator from 1970 to 2000, concurred. She relates that industry financial claims are “not justified” and believes such claims are unpersuasive.

[See Christopher H. Schmitt, “The New Math of Old Age,” *U. S. News & World Report* (Sept. 30, 2002), full article available for purchase at [www.usnews.com/usnews/issue/020930/health/30homes.htm](http://www.usnews.com/usnews/issue/020930/health/30homes.htm) along with its two sidebars, “Home \$weet Home” ([www.usnews.com/usnews/issue/020930/health/30homes.b.htm](http://www.usnews.com/usnews/issue/020930/health/30homes.b.htm)) and “Scrimping on Care” ([www.usnews.com/usnews/issue/020930/health/30homes.b2.htm](http://www.usnews.com/usnews/issue/020930/health/30homes.b2.htm)).]

### Financing and Quality Information Means Better Care for Residents

There are direct links between providing more stable capital flows to the long-term care industry, giving consumers increased information on long-term care quality, and the ultimate health and well-being of the residents, according to Scully. Scully made his remarks during the 12th Annual Conference of the National Investment Center for the Seniors Housing & Care Industries (NIC) on October 17, 2002 in Washington, D.C.

Scully said his goal as a regulator is to create a system that leads to “much more predictability and stability in financing” for the long-term care industry. This will in turn lead to investors looking at the industry’s stocks as steady-growth investment opportunities and will attract better management as more qualified businesspeople seek careers in long-term care. The business should no longer be looked at as the “backwater of healthcare that nobody wants to be in,” he said.

However, one of the biggest problems now facing the industry is that 82 percent of funding for the average nursing home comes from Medicare and Medicaid programs, effectively making nursing homes the largest federal contractors in the United States, Scully said. That reliance on government funding creates “a total lack of predictability,” such as the ups and downs in Medicare and Medicaid reimbursements that brought both the more favorable margins of the early 1990s as well as the financial difficulties of recent years—including bankruptcies that in some cases “were good for the industry,” according to Scully. It also led to an overreliance on generating profits through programs funded by Medicare in order to subsidize inadequate Medicaid funding.

“There was some extremely stupid decision-making going on,” he said, referring chiefly to acquisitions of ancillary service companies that were, for a time, overreimbursed.

Scully pointed to public perception of nursing home quality as another major issue affecting the industry. While it’s relatively easy for consumers to learn who has the best hotels or rental car companies, discovering who operates the best nursing homes or hospitals is not easy and must change. “It’s a joke,” he said. “The federal government’s biggest business is healthcare and it’s the one place in our economy that has the least amount of consumer information. I’ve always felt the lack of information in healthcare about quality is outrageous.”

Other points and comments Scully made during the NIC keynote speech included the following:

- On what the industry should do to secure more government funding, Scully insisted that current Medicare reimbursement is more than adequate, but acknowledged that Medicaid funding at the state level is often inadequate. “The fact is we are

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## Federal and State Legislation

### Federal Legislation

#### Fatal Chronic Illness Act

**T**he Living Well with Fatal Chronic Illness Act of 2002 (H.R. 5139) would amend title XVIII (Medicare) of the Social Security Act to provide certain caregivers with access to Medicare benefits and amend the Internal Revenue Code to require an annual long-term care tax credit. In addition, the legislation would require the Department of Health & Human Services and Department of Veterans Affairs to develop programs to improve the delivery of appropriate treatment services to persons with fatal chronic illnesses. Retrieve bill summary, status, and full text online at <http://thomas.loc.gov>.

#### Alzheimer's Disease

**T**he Alzheimer's Disease Research, Prevention, and Care Act of 2002 (S. 2059) would expand the purposes of the National Institute on Aging by making Alzheimer's disease research a priority. It would require the Director of the Institute to: (1) undertake an Alzheimer's Disease Prevention Initiative, including accelerating the discovery of new risk and protective factors, rapidly identifying therapies and preventive interventions, and implementing effective prevention and treatment strategies; (2) conduct and support cooperative clinical research regarding Alzheimer's; and (3) conduct, or make grants to conduct, research concerning early detection and diagnosis, the relationship between Alzheimer's and vascular disease, and interventions designed to help caregivers. In addition, the measure authorizes the Director to establish a National Alzheimer's Coordinating Center to facilitate collaboration among Alzheimer's Disease Centers and Alzheimer's Disease Research Centers. Retrieve bill summary, status, and full text online at <http://thomas.loc.gov>.

#### Improving Access to Long-Term Care

**T**he Improving Access to Long-Term Care Act of 2002 (H.R. 4946) proposes, among other things, to amend the Internal Revenue Code to permit a deduction for an applicable percentage of eligible long-term care premiums paid by a taxpayer for coverage for the taxpayer, spouse, and dependents; modify consumer protection provisions for long-term care insurance; revise provisions pertaining to the excise tax on providers of long-term care insurance who fail to meet certain standards, adding requirements about disclosure of rating practices to the consumer and about suitability; and expand qualifying expenses for the 50 percent tax credit related to human clinical testing of drugs for the treatment of certain rare diseases and conditions.

The legislation defines an individual with "long-term care needs" as someone who: (1) has been certified by a physician as being unable, for at least 180 consecutive days, to perform at least two activities of daily living due to loss of functional capacity; or (2) requires substantial supervision due to severe cognitive impairment and needs reminding or cuing assistance to perform at least one activity of daily living; or (3) is unable to engage in age appropriate activities. Retrieve bill summary, status, and full text online at <http://thomas.loc.gov>.

### State Legislation

#### Tort Reform in Kentucky

**I**n a statement released December 6, 2002, the Kentucky Hospital Association and Kentucky Medical Association joined together to applaud legislation calling for medical liability reform as the first bill introduced in the upcoming session of the Kentucky General Assembly. Both organizations cite medical liability lawsuit abuse as a major cause

of skyrocketing liability insurance premiums. Senate Bill 1, sponsored by state senator David L. Williams (R-Burkesville), proposes to amend the Constitution of Kentucky to add a new section allowing the general assembly to limit noneconomic and punitive damages, provide statute of limitations on actions, and require alternative dispute resolution in cases involving health care providers licensed or certified by the state. The amendment would give the people of Kentucky the right to decide whether the state legislature should have the power to enact the same reform other states are signing into law. ■

► *continued from page 12*

vastly overpaying in Medicare and we're happy to do that for a while. But we need to have a real serious public debate about the financing of long-term care and who's paying for it and what the margins are," he said. Scully advised that industry advocates should lobby at the state level for increased funding.

- On the patient litigation and liability insurance crisis, he said the long-term care industry must join forces with other healthcare providers on Capitol Hill and make tort reform their number-one issue until they secure relief.

- On Congress: "From the point of view of actually doing anything for healthcare, this was the most nonfunctional year (2002) I can remember," said Scully, who began his career in the late 1970s.

- On long term care insurance, he said there is a need for more people—especially those in their 50s—to obtain insurance. This ultimately will bring more private payors into the system.

An audiocassette tape of Scully's address is available for purchase through NIC's online bookstore, [www.NIC.org](http://www.NIC.org). ■

## Internet Resource Review

### Using the Internet to Research Elder Falls

Christopher B. Hopkins

**M**ore than 50 percent of nursing home residents fall annually; more than 40 percent experience repeat fall occurrences. About 11 percent of falls result in significant injury (e.g., hip fracture), often leading to hospitalization and further physical deterioration. Falls are a major cause of death among older adults. About 20 percent of all fall-related deaths occur in the 5 percent of elderly persons residing in nursing homes. Falls and fall-related injuries are a leading cause of lawsuits against nursing homes. According to a recent Florida study, falls account for 57 percent of allegations in nursing home lawsuits. A facility's alleged failure to protect a resident from falling has been considered negligence in some cases, and health care malpractice in others.

There are three primary sources of "falls" information on the Internet: government and public service agencies, medical product retailers, and nonprofit organizations. Each source provides a wealth of statistical information and, quite frequently, differing risk-management fall prevention standards. Defense counsel likely will focus on statistics that reveal the high frequency of falls and the associated difficulty of prevention. Facility counsel may defend the care provided by seeking the most favorable standard among the many proposed standards. Similarly, plaintiff's counsel will consider the differing standards when assessing the liability aspect of a potential case. Finally, plaintiff and defense counsel should investigate any commercial products used by the facility and be cognizant of pending federal legislation (e.g., Elder Fall Prevention Act).

#### Government Resources

Many government and public service agencies furnish detailed infor-

mation about senior living and the risks of elder falls (i.e., home- and community-based as well as those occurring in institutions). Knowledge gathered from these agency Web sites should assist the litigator in educating the jury about the fall causes and interventions.

For instance, the National Safety Council (NSC), a government-chartered public service organization, provides numerous fall-related articles, resources, and links on its Web site ([www.nsc.org/issues/fallstop.htm](http://www.nsc.org/issues/fallstop.htm)). The materials describe fall prevention methods and relate the cost associated with falls in the context of the Medicare and Medicaid programs. The NSC founded the National Alliance to Prevent Falls As We Age ([www.nsc.org/fallsalliance.htm](http://www.nsc.org/fallsalliance.htm)), which seeks to create a network to develop and disseminate fall-prevention information to its members. The Alliance has a science, technology, and resource task force as well as a National Action Plan. Both represent a source of potential experts and authoritative resources for the litigator (e.g., "Preventing Falls As We Age," a .pdf file available at the NSC site). Further, the Alliance membership roster lists more than 50 organizations and their Web sites.

The Centers for Disease Control and Prevention (CDC) also relates information about fall prevention and cost, including an extensive bibliography of authors and texts ([www.cdc.gov/ncipc/falls/default.htm](http://www.cdc.gov/ncipc/falls/default.htm)). The National Center for Injury Prevention and Control, which is part of the CDC, provides a searchable database of fall statistics and information ([www.cdc.gov/ncipc/factsheets/nursing.htm](http://www.cdc.gov/ncipc/factsheets/nursing.htm)).

Finally, the Administration on Aging ([www.aoa.gov](http://www.aoa.gov)) Web site conveys additional resources concerning elder falls and other senior health risks.

#### Commercial Products

Not surprisingly, many medical product retailer Web sites explain the product, provide pricing, and share information about fall prevention (e.g., [www.americanmedicalalarms.com](http://www.americanmedicalalarms.com)). Bed-Check Corporation, a bed and mobility alarm manufacturer, sponsored a study investigating the relationship between bed alarms and falls. Read the overview at [www.bed-check.com/fall-prevention-study.html](http://www.bed-check.com/fall-prevention-study.html) and, if interested, purchase study results for \$20 per copy.

Senior Technologies, Inc., the creator of the WanderGuard system, has an extensive site detailing its departure alert, wireless monitoring, and mobility alarm systems. This and other similar Web sites depict digital images that may be used as demonstrative aids (provided copyright concerns are addressed). The sites also communicate information about the cost of each system, which may be relevant to your case. Visit [www.medicalshoponline.com](http://www.medicalshoponline.com) to find the cost of these types of medical devices.

Balance and mobility are intrinsically related to falls and several Web sites deal with these issues in the context of senior living. Neurocom International provides an interesting web article called "Identifying and Managing Elder Fallers" and links that define several commercial and standard assessment techniques (e.g., visit [www.onbalance.com](http://www.onbalance.com) and select "Falling in the Elderly"). Other balance equipment manufacturers likewise provide information about their products online (e.g., [www.medtrakonline.com](http://www.medtrakonline.com)).

Finally, remember to visit other commercial product Web sites that at first blush do not seem directly related to falls and fall prevention among older adults. The [www.hearingdepot.com](http://www.hearingdepot.com) site, for example, features articles about the relationship between ear disorders and falls (see [www.hearingcenteronline.com/newsletter/july00f.shtml](http://www.hearingcenteronline.com/newsletter/july00f.shtml)). Finally, [www.senior-fitness.com](http://www.senior-fitness.com) promotes its fitness

programs and books. This site may offer some insight into the relationship between exercise and an older adult's gait and balance.

### Nonprofit Organizations

Medical and senior citizen organizations also may offer position-papers and prevention advice online for consumers and caregivers. The American College of Emergency Physicians, representing emergency room physicians who treat the majority of elder fall patients, provides a summary of its journal article "Help the Elderly Cope With Falls" ([www.acep.org/1,309,0.html](http://www.acep.org/1,309,0.html)). Retrieve without cost the article's full text from the *Annals of Emergency Medicine* via mail.

The American Academy of Family Physicians also publishes an article on practical therapeutics that highlights research on the prevalence and risks of elder falls using some excellent graphs. The article can be found at [www.aafp.org/afp/971101ap/steinweg.html](http://www.aafp.org/afp/971101ap/steinweg.html).

Another article, "Preventing Falls in the Elderly," available from the Colorado State University Web site ([www.ext.colostate.edu/pubs/consumer/10242.html](http://www.ext.colostate.edu/pubs/consumer/10242.html)), addresses the link between osteoporosis and falls, and supplies links and bibliography resources.

Other useful nonprofit organization Web sites providing elder fall information include [www.aarp.org](http://www.aarp.org), [www.stepsafe.com](http://www.stepsafe.com), and [www.healthatoz.com](http://www.healthatoz.com).

### Federal Legislation

The pending Elder Fall Prevention Act (EFPA) has prompted an abundance of up-to-date information on elder falls. Find the text and legislative status for the EFPA (S. 1922), introduced in February 2002, at <http://thomas.loc.gov>. The bill seeks to create an educational campaign to provide seniors and their caregivers with prevention information regarding falls. Bill text references government statistics that can be used by

defense counsel to suggest that falls are endemic and that a resident's fall in a nursing home should not be considered a sign of immediate liability. U.S. Senator Mikulski (D-Md.), a bill sponsor, offers periodic updates on the measure on her Web

site (<http://mikulski.senate.gov>). In addition, find the complete text of oral testimony concerning the EFPA offered by the vice president of the National Safety Council before the Subcommittee on Aging at [www.nsc.org/news/bj061102.htm](http://www.nsc.org/news/bj061102.htm).

## Using the Internet to Research Pressure Ulcers

Christopher B. Hopkins

**A**ccording to a recent study undertaken in Florida, nearly 60 percent of nursing home lawsuits involve allegations of developing or worsening pressure ulcers, also known as pressure sores, bedsores, decubitus ulcers, or decubiti. Many long-term care lawyers handle these cases without understanding the physiology of bedsores beyond associated terms such as *Stage IV* or *eschar*. With the amount of litigation in this area, lawyers can rely upon the Internet, among other resources, to research the medical aspects of pressure ulcers (e.g., clinical practice guidelines) and to ascertain which health care organizations are challenging how nurses evaluate and respond to skin breakdown.

### Authorities Online

Available online is a set of authoritative clinical practice guidelines which most health care providers universally recognize as the authority on pressure ulcers. "Clinical Practice Guidelines 3: Pressure Ulcers" and its companion "Clinical Practice Guidelines 15: Pressure Ulcer Treatment," both developed by the Agency for Healthcare Research and Quality, are reliable resources used for over a decade by health care providers caring for or seeking to prevent pressure ulcers as well as plaintiff and defense counsel trying to deter-

mine adherence to and/or deviation from the standard of care. The guidelines are short in length (about 100 pages) and not overly technical. An abbreviated "quick reference guide" version condenses the material further. Visit [www.ahcpr.gov](http://www.ahcpr.gov) and follow the prompt for the online versions of the "clinical practice guidelines." Even if counsel possesses a print copy, the online search function is extremely useful in evaluating cases and preparing for depositions.

The nursing admission assessment of each resident usually includes a risk-assessment tool for pressure ulcers that is meant to identify residents at high risk for developing pressure ulcers so that increased effort can be directed toward prevention. Two common tools are the Norton Score and the Braden Scale. Lawyers experienced in nursing home cases likely have seen facilities using these and other assessment tools. Learn more about such tools at [www.medal.org/ch21.html](http://www.medal.org/ch21.html).

### Plain English for Lawyers and Juries

In 1873, pressure ulcers were described as "purple or yellow [in color] from the extravasation of blood or bloody fluid." In 2003, however, this phrase proves inadequate when experts and counsel are attempting to describe a nursing home resident's pressure ulcer to

jurors. Accordingly, counsel must seek the best manner to explain pressure ulcer development and assorted treatment interventions. Several online resources provide simplified medical information designed to educate the public, primarily older adults, on the subject. These Web sites and their method of explanation can greatly assist attorneys in finding the right words to speak to a jury.

For example, [www.la4seniors.com/bedsores.htm](http://www.la4seniors.com/bedsores.htm), although not considered an authoritative source on pressure ulcers, offers a 15-page overview on the topic accompanied by clear explanations and photographs of ulcers at each of the four stages. The site also supplies links to several recognized authorities addressing pressure ulcer prevention and treatment. As with all Web sites, remember to consider the objectiveness of the information presented. For example, this site is hosted by a public service entity and arguably may be biased given its reference to settlement of ulcer cases exceeding \$1 million.

Likewise, [www.skinwound.com](http://www.skinwound.com) details sample nursing home care plans for different types and stages of ulcers that lawyers can compare to case documentation. The site also includes hyperlinks to brand-name medications along with detailed case studies. An interesting feature is a free mailing list for updates on wound products and treatments.

Many legal sites also devote Web pages to pressure ulcer education for lawyers. One medical expert site, [www.ldhpm.com](http://www.ldhpm.com), shares medical information with a slant towards those involved in litigation. Other expert service sites, such as

[www.expertlaw.com](http://www.expertlaw.com), borrow this material.

### Journals and Organizations

Many pressure ulcer-related journals are available online for counsel seeking up-to-date information and potential experts. Retrieve relevant articles from the *Journal of Wound Care*, [journalofwoundcare.com](http://journalofwoundcare.com), by article title or searchable format. Likewise, [www.woundcare.org](http://www.woundcare.org) is hosted by a well-respected Florida physician and boasts an online publication as well as a bulletin board that may impart expert advice on individual questions.

If the attorney is looking for groups, forums, journals, or products, [www.woundtx.com](http://www.woundtx.com) holds itself out as a “club” for interested medical professionals, and the homepage contains a phenomenal list of links. In addition, access nearly a dozen wound-related journals and obtain updates via e-mail.

Finally, the National Pressure Ulcer Advisory Panel, [www.npuap.org](http://www.npuap.org), provides a wealth of information as well as access to their newsletters that highlight current trends. The NPUAP presently is developing new definitions of “deep tissue injury” that may ultimately revise the medical standards in the pressure ulcer area. The organization’s conferences are educational and draw a fair number of lawyers (indeed, an October 2002 conference provided Florida continuing legal education (CLE) credits).

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## Tracking State Legislative Activity

Obtain legislative information directly from state legislative Web sites. An excellent source of information for such legislative activity is the Piper Resources Guide, [www.piperinfo.com/state/index.cfm](http://www.piperinfo.com/state/index.cfm), which supplies links to all 50 state Web sites, including the state legislatures. ■

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management policies that explicitly address the needs of the terminally ill; 18 states had policies that address the undertreatment of pain among the terminally ill. But some state laws were not as progressive; a number of them sanction doctors based on a prescription’s strength and duration, even though these standards have no clinical basis and do not account for the very high doses that some patients need. Also, some state laws prohibit doctors from prescribing opioids to terminally ill patients with a history of substance abuse.

### Numbers of Physicians and Nurses Certified in Palliative Care

Palliative care training for the nation’s physicians and nurses lags far behind the needs of the aging U.S. population. This is true for medical and nursing students, as well as for the hundreds of thousands of professionals already in practice. Since an ideal percentage of certified palliative care health-care practitioners has not been established, this measure was graded on a curve, with the higher-ranking states containing larger numbers of certified providers. Nationally, only about one-third of one percent of doctors in the United States are certified in palliative care (33 physicians for every 10,000 people). On average, about 0.4 percent of nurses are certified in hospice and palliative care (41 nurses for every 10,000 people). In the physician category, five states earned an A (between 0.5 and 1 percent of doctors were certified). Most states rated a C (between 0.2 and 0.4 percent of doctors were certified). In the nurse category, five states earned an A (between 0.7 and 1 percent of nurses were certified). Most states earned a C (0.3 to 0.5 percent of nurses were certified). ■

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develop and enforce storage, housekeeping, and debris-removal practices to reduce the building's flammable and combustibile fire load to the lowest feasible level. [See JCAHO Standards EC.2.10.2 and EC.1.5.] Review NFPA's Life Safety Code for further guidance on this topic.

#### **Facility Smoking Policy**

The organization also should develop and enforce a policy regarding resident smoking. [See JCAHO Standard EC.1.1.2.] For example, the policy may allow residents who meet identified criteria to smoke in a designated location environmentally separated from resident care areas or in a separate, well-ventilated room; require monitoring of resident smoking activity by staff, family, or volunteers until the cigarette is "out and cold"; and prohibit residents from smoking while in bed. One goal of such a policy is the elimination or reduction of a smoking-related fire hazard that may cause harm to the resident, facility staff, and/or visitors. Communicate

this policy to staff, residents, and visitors.

#### **Emergency Power Source**

Emergency power-supply systems automatically supply illumination or power to critical areas and equipment essential for safety to human life (e.g., illumination for safe exiting and ventilation). Federal regulation dictates that an emergency power system must furnish adequate power to light all entrances and exits; operate fire detection alarm and extinguishing systems; and maintain life support systems in the event normal electrical supply is interrupted. [See 42 C.F.R. § 483.70(b).]

Accordingly, a facility should

properly install a reliable emergency power system that is adequately sized, designed, and fueled to provide electricity to alarm systems; ensure exit route and exit sign illumination; operate emergency communication systems; deliver electricity to blood storage units, areas where life-support equipment is used, at least one elevator (e.g., to use for nonambulatory residents), medical air compressors, medical and surgical vacuum systems, and special care units. [See JCAHO Standard EC.1.7.1.]

The facility should maintain, test, and inspect the chosen emergency power supply system often. [See JCAHO Standard EC.2.10.4.1] ■

### **White House Launches New Web Site on Disabilities**

On October 15, 2002, the Bush Administration launched a new Web portal designed for people with disabilities, called DisabilityInfo.Gov, as part of the President's New Freedom Initiative. It offers Americans with disabilities—and their families, employers, and service providers—with one-stop access to information and programs that facilitate their day-to-day living. The site is a multiagency initiative with information on civil rights, education, employment, housing, transportation, and more. ■

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