

## *Navigating the Legal Minefields*

**Avoiding Litigation in Your Facility**  
By Kathleen Martin, RN, MSN, MPA, LNHA, CPHQ

### Program Goals

- ~ Relate regulatory and legal standards of care to clinical and administrative practice in LTC and other healthcare facilities.
- ~ Discuss Torts, negligence and proximate cause.
- ~ Discuss the common legal pitfalls in nursing practice
- ~ Demonstrate 3 major areas the plaintiff must prove:  
*Existence of duty; Breach of duty; Injury*
- ~ Discuss and apply standards of care to various cases.
- ~ Relate how good risk management practices can prevent such suits.
- ~ Trace the legal process: from discovery to trial/settlement.
- ~ How to improve documentation to avoid litigation.

### ***Obligatory Lawyer Jokes.....***

The National Institutes of Health have announced that they will no longer be using rats for medical experimentation. In their place, they will be using attorneys. They have given three reasons for this decision:

1. There are now more attorneys than there are rats.
2. The medical researchers don't become as emotionally attached to the attorneys as they did to the rats.
3. No matter how hard you try, there are some things that rats won't do.

Why are deceased lawyers buried 12 feet under,  
when everyone else gets buried only 6 feet under?

***Because down deep lawyers are really good  
people.***

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Be very afraid!!!!



- ~ Suing owners
- ~ Suing Administrators
- ~ Suing DNs
- ~ Deposing Aides

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Medical Errors: The Scope of the Problem

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## An Epidemic of Errors ..

IOM Rpt-99 %To Err is Human+aprox 98,000 people die in hospitals annually as result of medical errors.

Pres Clinton ordered the Quality Interagency Coord Task Force- to make recs on this and improve pt. safety.

Costs: 10 yrs ago, est at \$38 Billion/yr; \$17 B are associated with preventable errors.

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When surveyed, most fear {61%} being given wrong drug. {then interactions, compics from medical procedure}.

75% think it is result of failure of individual providers.

### ***It's a Systems Problem:***

Study revealed that by including a pharmacist on rounds reduced errors r/t medic ordering by 66%.

Having standardized guidelines, protocols, equipment.

Computer technology to bar-code for ID, {done throughout VA system}.

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### ***Search:***

Medical Errors-voluminous

AHRQ

Joint Commission-National Patient Safety Goals: 9

Here are a few:

1. Avoid look-alike-sound-alike meds
2. Proper pt identification.-2
3. Read back for verbal orders
4. Critical values-timeliness of reporting
5. Standardize abbreviations-Do not use list
6. Fall prevention

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### Crew Resource Management .in short

Underlying CRM is the premise that human error is inevitable as well as a valuable source of information. The goal is to prevent work overload situations that compromise situational awareness that can lead to errors.

There are three lines of defense with error countermeasures.

First there is **avoidance** of error.

The second is **trapping** incipient errors before they are committed.

Lastly is **mitigating the consequences** of those errors which are not trapped.

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Organizations must communicate their understanding that errors will occur, and should adopt a non-punitive approach. In addition to normalizing error, organizations need to take steps to identify the nature and sources of error in their operations.

CRM is not and will never be the mechanism to eliminate error in high risk situations such as healthcare or aviation. Error is an inevitable result of the natural limitations of human performance in complex systems. CRM is one of an array of tools for organizations to manage error predicted with the potential to occur.

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### Error Management

The following strategies are utilized during the CRM process:  
standardized communication, team briefings, team debriefings, situational awareness, decision making, leadership strategies, effective teamwork, and critical language vocabulary and usage.

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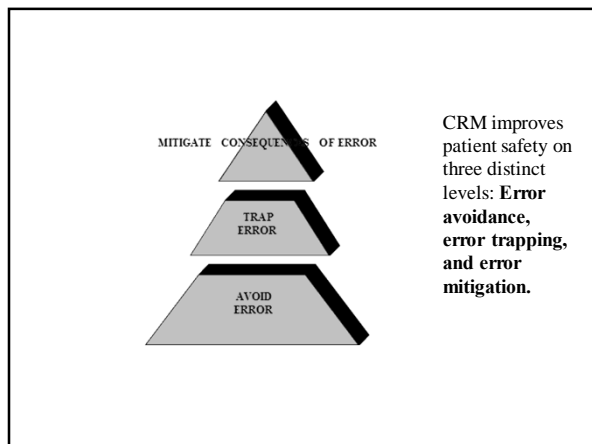
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**TORTS**

- ~ A tort is a civil wrong
- ~ Committed against person/property
- ~ For which a court provides a remedy
- ~ In the form of damages.
- ~ Negligence is a form of a tort
- ~ Intentional torts: Battery, defamation, false imprisonment, disclosure of confidential info, etc.

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**NEGLIGENCE**

- ~ The unintentional commission or omission of an act that a reasonably prudent person would or would not do under given circumstances.
- ~ A form of conduct caused by carelessness that constitutes a departure from the standard of care.

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## DEGREES OF NEGLIGENCE

### " ORDINARY:

- . THE FAILURE TO DO WHAT A REASONABLY PRUDENT PERSON WOULD DO

### " GROSS: The intentional or wanton omission of care that would be proper to provide.

### " ELEMENTS OF NEGLIGENCE:

- . Duty to care
- . Breach of duty
- . Injury
- . Causation

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## To Recover in a Cause of Action, the Plaintiff Must Prove;

### " THE EXISTENCE OF A DUTY

- . An obligation to care
- . To conform to the required standard of care
- . {Ex: med error: mfg, Pharmacist, MD, Nurse-all have different duties/soc}

### " BREACH OF DUTY:

- . Failure to adhere to obligation
- . Failure to conform to standard of care

### " AN INJURY THAT IS CAUSALLY RELATED

### " DAMAGES

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" There are Statutory and Regulatory requirements that, if not met, will lead to strict liability and in some cases treble damages and attorneys fees.

" {See, NJSA 30:13-1, et; NJAC 8:39-1 {Nursing Home Reform Act}}

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## Common Forms of Negligence:

- " Failure to take adequate history
- " Failure to note allergies
- " Failure to identify the pt.
- " Medication errors:
  - . Wrong med
  - . Wrong pt.
  - . Wrong time
  - . Wrong dose
  - . Wrong route
  - . Wrong technique
  - . Failure to adhere to aseptic technique
- " **Failure to observe and report changes on pt. condition.**
- " **Failure to communicate: to supervisors, peers, doctors**



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- " Failure to adequately supervise pts
- " Use of defective equipment
- " Failure to keep current
- " Safety issues:
  - . Side Rail entrapment issues
  - . Restraints
  - . Pt. falls:
    - SR left down on those deemed necessary
    - Medicated pts. Left unattended
    - Wheelchairs left unsecured, unlocked.
- " IV line or catheter care
- " Failure to keep current
- " Personal liability:
  - . Slander or libel
  - . Damage or theft of property (pts)
  - . Abuse
  - . Invasion of privacy
  - . Breach of confidentiality

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Sample 10 page claim/complaint

2. \_\_\_\_\_ resided with the Defendants from on or about October 2, 2007 to January 15, 2008.

3. During \_\_\_\_\_ residency, Defendants failed to exercise the degree of care, skill, and learning required, and expected by \_\_\_\_\_ and his family, of a reasonable, prudent nursing home. Jack \_\_\_\_\_ will prove that Defendants acted in a reckless disregard and showed conscious indifference to the health and well being of their residents including \_\_\_\_\_ and that this manner of operation was willful and intentional on the part of the Defendants.

4. Defendants care and treatment deviated from the standard of care in, including but not limited to:

- a. Failing to provide sufficient competent staff to provide care;
- b. Failing to provide adequate supervision of the staff;
- c. Failing to provide care and treatment commensurate with State and Federal Regulations applicable to nursing homes in West Virginia;
- d. Failing to ensure that Jack \_\_\_\_\_ needs were met;
- e. Failing to ensure that Jack \_\_\_\_\_ needs were assessed and reassessed; and
- f. Failing to ensure that \_\_\_\_\_ maintained adequate nutritional status.

5. In addition to a claim under the "medical professional liability" status, a claim is intended to be brought for, including but not limited to:

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- a. General Negligence against all Defendants, this includes but is not limited to those acts and/or omissions by Defendants that do not fit within the definition of "health care" as defined by Vt. Va. Code §55-79-2.
- b. General Negligence against the administrator, this includes but is not limited to the improper management and oversight of the nursing home causing a condition and atmosphere that placed the residents including Jack, \_\_\_\_\_ in harm's way and did therefore result in harm to Jack Willard.
- c. Wrongful Death against all Defendants, this includes but is not limited to those acts and/or omissions by Defendants that do not fit within the definition of "health care" as defined by Vt. Va. Code §55-79-2.
- d. Malice and/or gross negligence against all Defendants, this includes but is not limited to the willful and wanton operation of the nursing home which caused the care that was provided to residents including \_\_\_\_\_ to be grossly below the standard of care and showed a conscious disregard to the health wellbeing and safety of the residents including \_\_\_\_\_.
- e. Fraud against all Defendants, this includes but is not limited to the intentional and knowing misrepresentations made by the Defendants and/or their agents or employees to \_\_\_\_\_ and his family about the quality of care and/or services that would be \_\_\_\_\_.

... gone on for ... →

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***I must emphasize.....***

- É **Failure to Monitor Properly:**  
Be sure frequency of monitoring is specified in MD orders or P & Ps.  
Always monitor the condition and status. Look at outcome.  
Document frequency of monitoring.
- É **Failure to Communicate:**  
Address all symptoms and signs of distress.  
Promptly bring distressing symptoms and changes to the MD attn.  
Document this notification and result.
- É **Failure to Follow Prescribed Orders and/or Established Protocols:**  
Realize that any departure from a PMD order or facility protocol can be very difficult to defend.  
Bring questionable orders to the attn of the MD and/or Supervisor.  
Know your nursing standards of care.

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**Doctrine of Respondeat Superior**

- “ Has been used in determining negligence.
  - . States that one must show by expert testimony:
    - “ The ~~standard~~ of care
    - “ That the defendant deviated from the SOC
    - “ That as a proximate result of the defendant's negligent act or omission, the plaintiff suffered injuries which would otherwise have occurred.+
  - “ The facility is responsible for individual staff actions.

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## PROXIMATE CAUSE

- ~ Essential element of a medical malpractice action.
- ~ The mere occurrence of an injury does not prove negligence.
- ~ Injury must be causally linked to a breach of duty on part of defendant.
- ~ Must be *reasonably probable* or *more likely than not* that the defendant's action was a *substantial factor* in bringing about the injury/death.

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## REASONABLE MEDICAL PROBABILITY

- ~ Proximate cause is not established unless there is a probability, rather than mere possibility, that negligence caused the injury.
  - . *"Within a reasonable degree of medical probability...."*
- ~ Expert testimony is {virtually} always required to draw the connection between negligence and the injury.

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## FORESEEABILITY

- ~ WAS THE INJURY FORESEEABLE?
  - Can we foresee that a confused, unsteady res will fall?
- ~ Res ipsa loquitur= latin phrase = *the thing speaks for itself*; is a rule of law that may be applied. {retained sponges during surgery.}

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## STANDARD OF CARE

- ~ What is **REASONABLE** under circumstances
- ~ Plaintiff must first establish the standard of care- was it a deviation?
- ~ Good faith is not an issue; meaning well is irrelevant.
- ~ Standards are determined by the profession.

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## Standards of Care conqñ õ

- ~ Policies, Procedures, and Protocols-failure to adhere may be evidence to meet SOC.
- ~ Expert testimony-Most common method.
- ~ THE PLAINTIFF HAS THE BURDEN OF PROOF AND MUST PROVE BY PREPONDERANCE OF THE EVIDENCE USING AN EXPERT.
- ~ ..except whenõ
  - . Common knowledge
  - . Res Ipsa Loquitur

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## Standards of Care

- ~ ANA-Scope of Practice
- ~ JCAHO
- ~ Federal Long Term Care -42 CFR Section 483
- ~ State Department of Health/Administrative Code
- ~ Specialty
- ~ OSHA
- ~ Agency for Health Care Policy and Research (ACHPR)
- ~ Other Health Care Organizations in regard
- ~ Facility Policies and Procedures
- ~ What is Safe
- ~ Etcõ ..

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## Standards and Measures Relating to Medication Use

NQF    Endorsed Measures  
34 Safe Practices  
28 Serious Reportable Events

IOM    20 Priority Areas; Preventing Med. Errors and Overuse of Antibiotics

AHRQ    32 Quality Indicators  
27 Patient Safety Indicators

CMS    Core Measures  
27 HCAHPS

Joint Commission  
National Patient Safety Goals  
Med. Management Standards

Leapfrog Leaps Survey,  
NPP    National Priority Partnership

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If I get sued, how will  
documentation  
help/hurt me?




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Helpõ .then hurt meõ õ

- ~ You will know exactly what you did and when you did it.
- ~ Lack of memory replaced by good charting.
- ~ Thorough, legible notes look more professional
- ~ If you fail to prepare the documentation you are liable,
- ~ You will have difficulty remembering what, when, why you did it.
- ~ Can appear unprofessional
- ~ Poor recollection will appear defensive.

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### Legally Defensible Charting Strategies:

- ~ Write in ink and make the record %copyable+
- ~ Line through empty spaces
- ~ Addendums if it says %addendum+
- ~ Date and pt name on each pg.
- ~ Complete signature
- ~ Document chronologically
- ~ No entries in advance
- ~ Correct spelling and grammar
- ~ Write legibly-65% of text is illegible
- ~ Use only approved abbreviations
- ~ Know how to correct entries per policy-See %Correction of Medical Record Policy+

**A word on**

**E-Mail!!!**

**Meta data**

### INCIDENT CHARTING

- ~ **"Just the facts, ma'am"**
- ~ (no assumptions!)
- ~ Do not implicate anyone.
- ~ Form is designed to obtain facts of event only.
- ~ Any follow-up or investigation must be on a separate form.
- ~ Must have follow-up monitoring policy in place.
- ~ (after event, for how long do you assess- use pre-printed form).
- ~ Timely process for signatures, etc.. process in facility.
- ~ Notification of DN, Admin in timely manner prn.
- ~ Exact times of notification

#### **Follow-up notes should include:**

- ~ Interventions
- ~ Assessment specific to fall or skin tear, etc
- ~ Vital signs
- ~ General status

#### **DISCHARGE NOTES**

- ~ Date and time
- ~ Reason
- ~ Mode of transportation
- ~ Physical condition
- ~ Vital signs
- ~ Mental condition
- ~ Physician and family notification
- ~ Disposition of belongings and meds
- ~ Understanding of teaching for home care, etcõ .

### • More Documentation Reminders •

- ~ Make no conclusions: %~~It~~ appears+; %~~It~~ seems+• ..
- ~ Accountability for pt valuables
- ~ Chart pt's non-cooperative behavior
- ~ Do not label the pt: %~~A~~ known complainer+
- ~ Meticulous charting of meds and transcription thereof
- ~ Telephone orders: per %~~new~~+policy
- ~ Make late entries or addendum(s) ASAP
- ~ Avoid use of catch phrases:
  - . %~~Good~~ condition+
  - . %~~Pt.~~ had a good night+
  - . %~~Pt.~~ feeling better today+
- ~ Document safeguards for pt.
- ~ Note exact times of calls to MDs and critical treatments

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### **EXPIRATIONS**

- ~ Condition up to time of death
- ~ Resuscitation measures (or
- ~ Date and time vital signs ceas
- ~ MD notified
- ~ Family notified
- ~ Funeral home notified
- ~ Status of belongings




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### **Revisiting FOCUS Charting:**

- ~ Defined as:
  - . A current pt concern or behavior.
  - . A significant event in therapy.
  - . Acute change in condition.
- ~ FOCUS IS NOT a medical diagnosis (CHF with A-Fib)
- ~ Consist of :
  - . Data: %~~D~~+ Objective/subjective data which supports the stated FOCUS.
  - . Action: %~~A~~+ Immediate or future actions based on assessment/eval of condition.
  - . Response: %~~R~~+ Description of behavior or outcome in response to tx, care.

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### Evaluate Your Reporting & Investigative Process

- ~ Does incident/occurrence report capture all essential data?
- ~ How thorough {and honest} is your investigative process?
- ~ Is there confidentiality to the system?
- ~ What are the steps to follow in incident reporting?
- ~ Is there a local office, process for incident review?
- ~ Do you know what is reportable {to the State . re: Patient Safety Act}?
- ~ Do you know how to write such reports to Reg. agency?

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- ~ How do you know what deficiencies exist?
- ~ Who receives this information?
- ~ Who provides this information?
- ~ With whom is this information shared?
- ~ Has a committee been appointed to review incidents?
- ~ Risk Management system?

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### Equipment Related Incidents

- ~ Preventative maint system?
- ~ Document name, manufacturer, control number and other identification
- ~ Suspected malfunction, document facts relating to malfunction
- ~ Remove equipment from service, secure it for later testing
- ~ Independent evaluation of equipment

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## Your Role in Risk Management

- ~ Employees are first line of defense
- ~ Eyes and ears of the organization



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## Risk Identification

- |                          |                   |
|--------------------------|-------------------|
| ~ Incident Reports       | ~ Community       |
| ~ Summons & Complaint    | ~ Media           |
| ~ Grapevine              | ~ Regulators      |
| ~ QA/QI Monitors/PI Cmte | ~ Complaints      |
| ~ Walking rounds/cmtees  | ~ Industry Trends |

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## Risk Analysis

- |  |   |
|--|---|
| ~ Determine Frequency of Occurrence/Loss | ~ Determine Effect - Potential Loss on Organization |
| ~ Determine Probable Severity            | . Financial & Operational                           |
| ~ Determine Possible Severity            | . Subjective Opinions & Subjective Data             |

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## Risk Control Techniques

“ Techniques to Minimize Cost and Losses That Strike an Organization

- . Risk Avoidance
- . Loss Prevention
- . Loss Reduction
- . Segregation of Exposure Units

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## Risk Avoidance

“ Abandoning or Not Engaging in an Asset or Activity Rather Than Accepting the Associated Risk

“ *The Only Risk Control Technique That Completely Eliminates the Possibility of Loss from a Given Exposure is to Choose Not to Engage in That Activity or Operation*

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## Loss Prevention

“ Reducing or Eliminating the Chances of Loss

- Examples
  - Surgical Instrument Counts
  - Carpeting Floors
  - Infection Control Procedures
  - Safety Programs
  - Credentialing
  - Effective Hiring and Screening
  - Monitoring of Care
  - Fall teams/Clinical rev.

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## Loss Reduction

~ Reducing the Potential Severity of the Loss (Minimizing the Effect of Loss)

~ Examples

- . Team to Respond to Cardiac or Respiratory Distressed Patients
- . Sprinkler System
- . Disaster Plan
- . Crisis Management Team

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## Segregation of Exposure Units

~ Separation:

- . Dividing Between Two or More Separate Locations an Asset or Operation Which Could Be Performed at a Single Location (Reduce the Risk of Loss in a Single Event)

~ Combination:

- . Combining Widespread Exposures to Make Losses More Predictable (Law of Large Numbers)

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## BRIDGE THE GAP BETWEEN RISK & QUALITY

- ~ GET A GRIP ON ORGANIZATIONAL USE OF QA AND QI DATA-Data usage alignment.
- ~ FLOW CHART DATA-- USE AND ACCESS
- ~ IDENTIFY NEED TO KNOW REQUIREMENTS
- ~ Regular Quality Indic audits; rev P & Ps

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## COMMUNICATION

- ~ Studies have proven that face to face communication with patients and their families and prompt reporting of complications and incidents **greatly diminishes the chances that you will be sued.** (Harvard, 19906 .)
- ~ Create relationships with pts/families.
- ~ JC states that the biggest case of errors, Adverse events is mis-communication or lack of among staff.

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## If named in a suit

- ~ Be prepared
- ~ Be professional
- ~ Be courteous
- ~ Cooperate with Counsel
- ~ Be honest and truthful
- ~ Do not blame others
- ~ Do not alter records

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## Some Memorable Cases

- ~ 80% are falls; wounds, IVs, med admin.; mixed
- ~ Levin & Perconti (Porcello) Chicago: **escalating agitated behaviors; assaulted other resident, then fell and had heart attack. Nurses's notes stated: continuous agitation but nothing done....in deposition, nurses stated "that's the way he is."**  
Poor care planning. **Won 1.4 M**
- ~ (Sizemore), Chicago: **pt falling, noting bruises, no notification, etc; climbed over rail ---nurse notes no injury. Wife find pt grimacing in pain 3 days later-x-ray order-done with results 2 days later=fx hip. Dies 5 days later. Assessments/care plans not done. Settled favorably to plaintiff.**
- ~ Rogish & Richardson (Halloran), Chicago: **Pt demented, on coumadin, after aide handled roughly (admitted and fired for), pt had bruising from head to thigh; ER stated from trauma--police involved;**
  - Related issues: communication with aides/staff on coumadin side effects; INR tracking; staffing.
- ~ Cases where they get the SDOH Statement of Deficiencies-Trying to defend KY facility with (year of injury) 15 def, 4 Gs.

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**More case examples....**

ALF-Facility had in place %policy+call DN if pt falls, anything happens before call 911.

Pt. had sx and was deteriorating , later fell; aide called DN 2x night shift. No response. Did not send pt to hosp {911} until 7 am when day nurse came in.

Depositions were horrendous!

Aide said she was told not to call 911 first.

**How to defend??!! Know your policies and who is making them!**

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**...still more horror stories...**

Current Case {defending} Hosp:

85 y/o alert, oriented woman, periods of confusion. Adm to hosp from ALF/hospital for rehab.

Has high risk for falls -done on daily basis and adm.

Dtr wants SR up. When she comes in they are always down. Told they can't use rails-against law+Nrs dep says contrary.

Pt. fell broke hip. A lot of %failures+listed in complaint.

Named 2 nurses along with facility. {see next slide }

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**Con't...**

Assessed as high risk.

No CP present, let alone for Falls.

Tell her to use call bell, documented, yet doc that she is confused.

Not toileted, on Lasix, on benzo. Also BP was low in am prior to fall, on anti HTN med.

MD later said that the fall %was preventable+ to dtr!!!  
{thanks for the help!}

Issue of glasses/hearing aide-not provided to pt.

No pt educ. **How to defend you???**

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### More cases

- " Demented, confused high risk Pt falls, fx hip, declines; continuous notes on % instruction/telling pt to use call bell+ Care Plan limited.
- " Abuse Case-NJ: Aide clearly abused res-hit with diaper-witnessed. Fired, criminal charges. Suing the facility for mis-hiring, screening, training.
- " Wounds-see a lot of this
  - . Ensure admission {readmission} status is properly assessed and recorded. {Also from Dialysis}.
  - . Weekly skin checks, progress.
  - . Consistent wound doc, with actions {treatments, etc }
  - . MD note on unavoidable; PVD, etc Would help.
  - . Family notification-letter to family.

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### More Examples

- " Suing Administrator personally: KY: {def} pt. died several days after becoming confused; res for 4+ yrs; quad. Died of infection.
- " Suing DN personally: {NJ}: {def}. Pt arrested/coded after being found with legs over bedside, trach out, restraints; Spanish speaking only. Death cert=asphyxiation.
- " ....**Are your records in order?????.....**

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### Being Deposed!

- " You feel like you committed murder in 5 states!
- " You can never be prepared-and no one prepares you!
- " In the end you are torn to shreds usually unless you have done the reasonable thing.
- " Areas to shred:
  - . Your experience & education; CV
  - . Your judgment
  - . Facility orientation, P & P, etc
- " See sample depositions in packet ..

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õ Before we endõ important to remember!!!

" Falls:

- . risk assessments on adm, on schedule?
- . Reassessed after admission?
- . Care plan with updates, re-evals? Prev modes in place?
- . IDCP notes?

" Wounds:

- . Adm assess important!
- . Skin assess done?
- . Care plan for prev in mod to high risk?
- . Weekly wound measurements, etcõ ? Skin checks weekly.

" Pain:

- . Same as aboveõ

" Know your standards of care, regs.

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***Be Proactive....***

***Not Reactive!!***

***Learn from other s' mistakes!***

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Let's go to a Deposition



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