REDUCING RISKS IN NURSING HOME CARE

An Interview with Sean Doolan

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Pat: This is Pat Iyer with *Avoid Medical Errors* where the aim is to help you avoid becoming injured. We teach you how to be a good patient advocate for yourself and know the right questions to ask in order to maintain your health and your safety when you are part of the healthcare system.

Sean Doolan is with me today. He is an attorney who represents a particularly vulnerable population in our country and that is individuals who are in nursing homes and assisted living facilities. Sean, can you tell our listeners how you became involved in representing plaintiffs in malpractice cases?

Sean: Sure, and good afternoon, Pat. Thank you for this invitation and giving me this opportunity. It was in 1997. I was working as a prosecutor in ~~Broward~~ County, New York, and a great uncle of mine was in a nursing home in the Bronx. My mother had asked me to visit him. I didn't know him, but after spending some time with him I learned that he was being neglected. They were forcing him or attempting to force him to take psychotropic medication, which he refused to do. It's a rather long story, but I couldn't find a lawyer who would advocate for him.

Pat: Just for the sake of our listeners, Sean, could you explain what psychotropic medications are?

Sean: My uncle had early stages of dementia and he was exhibiting some behaviors where he was hiding food. He was a product of the Great Depression. And in an effort to better control him and manage those behaviors (that was the argument they made) they were administering these medications.

Pat: And the medications make him drugged or too sleepy?

Sean: They sedated him. He was a very active man prior to this and once he was on the psychotropic medication he became very depressed and withdrawn.

Pat: What happened next?

Sean: I couldn't find an attorney to take the case and I ended up resolving the issue with the nursing staff without having to institute a lawsuit. They stopped administering the psychotropic medication and eventually he was transferred to another facility where he remained. But it piqued my interest because there were no lawyers that I could find who were out there advocating for this very vulnerable population.

So around late 1999, I discovered there was a seminar for lawyers at Las Vegas who were interested in advocating for nursing home residents. I attended that and afterwards I started taking cases.

Pat: So you got in at the time that many attorneys were beginning to recognize the needs of this particular group?

Sean: That is true, at least here in New York it was just starting to emerge. I think in some of the sunshine states where there are larger elderly populations – Florida, Arizona and a few other states – there were attorneys in this field, but not in New York.

Pat: What was your initial response like in terms of being able to represent people? Did you have a lot of requests or was it slow in getting started?

Sean: It was slow in getting started simply because I needed to learn about the law and regulations that applied in nursing homes, confer with nurse experts and then start to develop a very simple marketing campaign which was nothing more than reaching out to personal injury attorneys and telling them that I was interested in taking on these cases and they were very happy to refer them. So within a year or so I was quite busy.

Pat: Wow. For the sake of our listeners who may not understand what a family or a nursing home resident has to prove in order to establish that there was malpractice, what are the pieces that go into that decision?

Sean: From a legal standpoint they have to prove that there was a departure from good and accepted medical care or nursing care and that that departure caused an injury and that the injury itself caused the resident conscious pain and suffering.

Those are the legal elements. What it basically boils down to is that the plaintiff has to prove that they didn't exercise good and reasonable care. There are certain standards that nursing homes have to adhere to and if they don't, it may result in a lawsuit.

There are also residents' rights violations. A lot of states have enacted residents' rights statutes and if those enumerated rights are violated then that may give rise to a legal claim.

Pat: Can you give us some examples of those resident rights?

Sean: Here in New York we have a residents' rights statute. Something as simple as not providing kosher food to a Jewish resident who has requested it would constitute a violation of their rights. When it comes to physical harm or abuse or neglect, there are more generic regulations. In New York if you can prove that there was a violation of a regulation, be it

a federal or state regulation that applies to a nursing home and there's been an injury – and an injury can be defined as an emotional one – that could give rise to a claim under the New York residents' rights statute.

I have a case that I'm looking at now where they altered the medical records after the resident had left the facility. That would give rise to a claim because we also have an underlying injury of bedsores. On top of that you have the altered records – that would give rise to a claim under the residents' rights statute.

Pat: Can you explain for our listeners what you mean by altering the medical records?

Sean: In this particular case they were making entries in the record after the resident had already been transferred from the nursing home to the hospital. In other words, they were documenting they were giving care that they could not possibly have given because he was in the hospital.

Pat: Do you have any understanding as to why they were doing that?

Sean: Having done this for quite some time now and having worked with legal nurse consultants, and also having to pose questions many aides and nurses, I've learned that often they will document at the beginning of their shift before they provided the care. They'll document for the entire shift. And in this case, they were documenting that they were emptying his urinal, feeding him, and providing basic custodial care when he wasn't even there.

Pat: That's amazing. Does that kind of behaviors happen very often?

Sean: Unfortunately, it does. It's the product of understaffing, sometimes poor training when the aides are in a rush. They don't see the importance of documentation and why it's important to be accurate. So they just often document at the beginning of their shift of the care they intend to give but often don't get around to do it.

Pat: At Med League, we get a fair number of calls from people looking for attorneys to handle their cases when there has been alteration in medical records. Apparently, we get calls because I wrote some articles in a chapter in a book on the subject so my name comes up in the Internet searches. We don't refer people to attorneys or work with people who don't have attorneys already, but it is a common concern that we got approached with. What from a legal standpoint are the implications of altering medical records?

Sean: First of all, it can constitute criminal behavior and we had criminal prosecutions here in New York through the Attorney General's Office. Some very high profile indictments have been brought against nurses and aides for documenting care they didn't give. But it also really puts into question the entire record and all of the care that was supposedly given. If they're willing to falsify records then can you really trust that they gave the care that they claimed to have given?

And it's also a violation of the residents' rights under the federal regulations and many states have regulations that mirror federal regulations. Nursing home records have to be complete and they have to be accurate. Clearly, by falsifying records they are neither complete nor accurate and therefore it's a violation of a regulation which can give rise to a violation of a resident's rights.

Pat: You mentioned that negligence, as well violations of a resident's rights, are fertile grounds for filing a claim in a nursing home case. What are some of the common reasons that people come to you and say that they want to file lawsuit?

Sean: Most of the time, they'll tell me that they don't want this to happen to somebody else. They want to make sure that the nursing home is held accountable for what it has done to their loved one. They understand that they can't turn back the clock for their loved one but they want to make sure that it doesn't happen again. And obviously, they want to see compensation for the poor care or neglect or abuse that has occurred. But

more often, they want to make sure it doesn't happen again and by bringing a case, they can improve the quality of care.

Pat: Have you seen instances where that has taken place? That the care has gotten better for other people?

Sean: Absolutely, time and again and that's one the reasons I continue to do this. I see their policies and procedures are outdated (need to be updated or revised). I see that they're not familiar with their policies and procedures. That's very common. The head nurse is not familiar with her policies and procedures.

So, by bringing the case and by questioning these witnesses, and by educating them about their own policies and procedures, I'm very confident that it has improved the quality of care. It's also had been a part of settlement. Families have asked me to include it as a part of the settlement that the facility makes certain revisions or that they institute certain training that was not taken place.

Pat: That's encouraging to hear. What types of cases have you found to be most successful for a plaintiff, and by most successful, meaning ones where some type of recovery occurred - either a settlement or a trial with a jury verdict and an award?

Sean: I would say, probably the number one type of case would be a pressure sore case, also referring to bed sores or decubitus ulcers, particularly if it's on the sacrum, on the buttocks area. When the pressure sore is on the ankles or the feet, if there's a sore on the ankles of the feet, that could be a little bit more challenging. But if it's on the buttocks, the hip or what we call the sacrum, those cases are almost always because of neglect and we're typically very successful in handling such cases.

Then we have occasionally an elopement. Somebody with dementia elopes from a facility. That should not happen and generally would not happen unless there is some form of neglect.

Pat: You're referring to running off to get married or something else?

Sean: (Laughs). We do this long enough and we talk like lawyers and healthcare professionals. You're right. If somebody is in a dementia unit, let's say who has dementia and she gets out of the facility in some way or elopes and then she gets harmed, that is an elopement case. I had a client who wandered out of an assisted-living facility, out of a dementia unit in an assisted living facility in the winter and she died as a result of exposure. That's a strong case; it's not supposed to happen.

I also would look at a case if a resident was dropped from a lift. If they're transferring a resident, taking him out of the bed and placing him on a chair and they're using a mechanical lift and he falls from the lift, that would be a strong case.

Pat: Can we talk the pressure sore situation before we talk about falls? You mentioned those were strong cases but medically what happens to a person when a pressure sore develops, say on the sacrum area?

Sean: When I'm evaluating a case, I'm looking to see if the sore is significant enough to warrant a lawsuit. What I mean by that, as you know, there are 4 stages of a bed sore from 1 to 4 with 4 being the most serious and we have exposed bone. I'm generally looking for a stage 4 bed sore and looking to see if there's an infection. So if we have an exposed bone, you have a breakdown on the skin that can lead to an infection which, as you know, has spread and caused someone's death and I see that very often. I see an infection. You've got to see bed sores followed by an infection and then followed by death.

Pat: Alright, thank you. I interrupted you when you're talking about falls.

Sean: I just wanted to say some fall cases, not all, are a little bit more challenging to investigate but some fall cases can be very strong. By working with legal nurse consultants and getting the records, getting the accident reports, we can do an investigation to see whether they

developed a care plan that was adequate to prevent any falls. If they fail to do that, there may be negligence.

Pat: Are there are certain types of falls that are more likely to be associated with the negligence than others?

Sean: Yes. Let's say there is a fall from a lift or a fall with an aide who is helping the resident walk to the bathroom. Often those are strong cases. Or they leave the resident unattended on the toilet when they shouldn't have. This gives rise to a strong case. If they fail to respond timely to the alarm or fail to even have an alarm, that's common error. The alarm is to warn if the resident is trying to get out of the bed. The alarm goes off. The staff are trained to come running but we have cases where despite repeated falls, they never institute an alarm, The resident is found in the bathroom and has a lot of time to go from the bed to the bathroom and then the alarm sounded. The staff would have had sufficient time to come in and attend the resident and prevent a fall from happening.

Pat: I see a basic dilemma as you're describing the alarm. The nursing home has to have enough people to be able to respond to get there quickly. Yet they are overwhelmed with a lot of care. They don't have enough people on that nursing unit and can't get there in time so they can't prevent that fall from occurring.

Sean: That's true and it creates a certain tension because the facility was unable to manage. "We don't have enough funding, we don't enough staff, and therefore falls are going to happen." But they don't tell the family that when they accept the resident. They don't tell the family and then it's only after the fact that they give that as an excuse. But regulations require that they have sufficient staff to meet the needs of the residents.

Now, they can't prevent every fall, that is true but when you see a pattern of falls and you see an unwillingness or failure to update and revise the

care plan to prevent future falls. Then you may have a case involving negligence.

Pat: When we think about the typical population in a nursing home, there are certainly some young people who are there but the majority of them are in their 60s,70s, 80s, and 90s, even 100s. How can these cases be worth much money when people are that old?

Sean: I think way back to why I got into this when we talked about that earlier. I got into it for a very personal reason that my uncle was in one, in a nursing home and I couldn't find a lawyer for him. The reason is the traditional view has been that we placed very little value on the pain and suffering of the elderly and that has been true of the judicial systems of lawyers and judges and to some extent, it's still true today.

I continually have to educate judges as to the value of these claims, as to the value of the pain and suffering of the most vulnerable people in our society other than children. But fortunately, attitudes are evolving and changing and juries are responding and we're seeing through the verdicts that they do value the elderly and they do value the pain and suffering that the elderly has endured at the hands of a nursing home when there's neglect.

Lawyers are just starting to see that these cases have value and are presenting them in a way, I think, that conveys to a jury, through with the help of experts, not only the negligence, the departures that we talked about inside the nursing home but the actual suffering of the resident. There used to be a school of thought that if you had dementia then you don't know what was going on so. Therefore you couldn't possibly be suffering.

But even though you're confused, you can still suffer and we're able to demonstrate that to a jury. Juries are responding and this has been a nationwide trend where the value of these cases has consistently got up over the last 10 to 20 years.

Pat: You know, I can remember an attorney telling me about 10 years ago that somebody with dementia couldn't feel a pain. I said, "That it's like saying that a baby who can't communicate can't feel pain. Would you believe that to be true? Oh no, of course not."

Sean: I think that's an excellent analogy. Judges, unfortunately, often have the same attitude.

Pat: We talked about some of the types of cases that are most successful in terms of pressure sores, drops from lifts, or while being transferred. I know that there are several other ways that people can get injured in nursing homes. What are some of the factors that would cause you to say that you don't want to handle a claim?

Sean: They're varied but I do see consistent patterns over time and one would be if the family of the loved one who want to bring the case have not been involved in visiting their loved one. They can't provide even a history. They didn't visit and they don't have a good reason for not visiting. They didn't have a relationship with the loved one. Those often are cases I would decline.

Pat: And why would that be?

Sean: It really comes down to the bottom line. A jury is typically not going to award money to a family member of a loved who is not involved on behalf of the resident. And it makes it more difficult to proceed with the case when you don't have a family member who really cares about what happened.

The other thing is you have got to look to see if there is a serious enough injury. You can have negligence but not a serious injury. So a good example of that would be. . . I'm talking about the nursing home case. Let's just talk about a car accident -somebody rear ending someone who is sitting at the red light but the driver who was hit was not injured. Yes, there is negligence because he was hit from behind but there is no injury.

So I look to see, did the fall of for the nursing home resident cause a serious injury, let's say a fracture. There could be a bump on the forehead that's going to heal in a few days but I'm not going to pursue that case. So, I'm looking for a serious injury or serious violation of a resident's rights which doesn't necessarily mean a physical injury. If there's a mechanical restraint of a resident or physically restraining a resident that is unnecessary, this is a violation of the regulations. That could give rise to a claim but we're looking for the actual injury itself.

Pat: Okay.

Sean: Actually, another consideration that would be, if they don't call a lawyer, if it take a long time to call a lawyer. I mean, I'm close to the statute of limitations which varies from state to state. But if it takes a year to call a lawyer and what we're up against statute of limitations, it's just not enough time to investigate the case.

Pat: What is the statute of limitations?

Sean: In New York and I can only speak of New York at the moment, you have to bring the claim, if it is a negligence claim or that's just a theory of liability, then it's 3 years. You have to actually initiate your claim within 3 years. If it is medical malpractice, it's 2 ½ years. If it's a resident's rights violations, it's 3 years. So, you actually to go to court and file your claim within those time frames. If it involves a municipality, you have to file a note called a notice to claim or just put the municipality on notice within 90 days that you intend to file a case.

Pat: That number of years I'm assuming could vary from state to state?

Sean: It can vary from state to state. In New York, if the resident has dementia and dies, you may get an extension of those time frames.

Pat: Let's say a 100 people call you and want to have you investigate a

claim involving a nursing home case. Approximately how many of those people would you retain as your clients?

Sean: I don't keep statistics but I've been doing this long enough to get a sense of numbers. Now, when you say retain, of course, that doesn't necessarily mean as a successful outcome. I actually would decline about one third. Just a thorough interview would reveal that there's not a case we can bring. The rest would be investigated further but only a handful would make it to a formal retainer, maybe 10 or less. Of those 10 or less, there would be a few that would result in initiation of a lawsuit. When I do accept the case and I do take it to court, the vast majority of time I win.

Pat: Okay.

Sean: But I said, less than 10% probably make it to the filing stage.

Pat: Let's assume that there are family members out there who don't contact you or any other attorney because they're concerned about repercussions on their loved one if they file a suit. Does this mean if a family member comes to you and says she is concerned about a pressure sore that her mother is getting in the nursing home and it's the only nursing home in town - does this mean this individual is going to be ejected out from the facility if they file lawsuit?

Sean: No. I've never seen that. I'm asked that questions a lot and I understand their concern. In my experience the facility is more careful, not less, but I always advise the family to do what is in the best interest of their loved one. And if that means transferring them, then transfer them. But don't let this lawsuit dictate your decision. You should decide based on what's going on in there, their best interest. They have to confer with healthcare professionals but I don't do that. I've never seen that happen. That's not to say it couldn't happen but I haven't seen it.

Pat: We talked about potentially 10 people out of that 100 whose cases you might take on, which leaves 90 people. You've turned down on their case for any variety of reasons. What can they do instead of filing a clam,

if they're concerned about the care that their loved one is receiving in the nursing home?

Sean: The state department of health helps them file a claim through the hotline. Every state has a hotline number. Then you can call and make a claim and the department staff will come in and they will do an investigation. And they will actually interview witnesses and review records and then issue a report, if there was a violation of regulations. That's a more formal approach. You could also work with a legal nurse consultant to help you interact with the facility to prevent this harm from happening again. If it's a fall, for example, you can order the records, have them reviewed, and then attend a care plan meeting after you met with the legal nurse consultant and attempt to advocate for your loved one or maybe there should be change in the care plan to prevent future falls.

You could also contact the State Ombudsman's Office and the State Ombudsman's Office. They have specially trained staff to advocate for the elderly. They're supposed to advocate for quality care and quality of life for nursing home residents. It's their job to resolve issues with the nursing home residents that they have with the nursing home. So, those are some things that can be done but the most important thing is to visit, to be present, and to be informed, and advocate for your loved one without being adversarial. It's not helpful in my opinion just be adversarial, unless that's your last resort.

Pat: Can you give any tips on how to approach nursing home staff that you're concerned about something without being adversarial?

Sean: I often find that there's a breakdown in communication when family come in and talk about that they've conferred with the lawyer and that X, Y and Z needs to be done. And instead the approach you can take is to ask to attend a care plan meeting and that's an interdisciplinary team. You'll have the nurse in there; you'll have physical therapy, occupational therapy, whoever is on that team to care for that particular resident. You

can go to that care plan meeting and express your concerns in a way that gets the point across but it's not unnecessarily adversarial.

You can also bring someone with you, a legal nurse consultant or a family member who you think might be able to articulate it better. But in my experience, the nursing staff will want to do the right thing and they want to provide good care but sometimes they need a push and sometimes they need someone who's going to advocate for the resident.

So, being there, being informed, and being consistent, and interacting with the staff in a way that's not adversarial is in my opinion the most advantageous way to proceed.

Pat: There has been some nursing research that confirms that, that shows that people at nursing home who have regular visitors receive better care than people who are never seen by their family members.

Sean: I'm not surprised by that but I cannot speak to that issue because the intakes that I take and the calls that I get are almost always from involved and informed family members and unfortunately despite that, there is still neglect. The ones that don't have an advocate, they're just unfortunate. There's no one out there and they don't make it to my office.

Pat: I understand what you mean. You mentioned earlier that the cases that go into court, that you take into court, have a high rate of verdicts in favor of the plaintiff. How many of those cases that you're involved in every year actually end up in court?

Sean: The cases that I handle all end up in court, just to be clear about what I mean by court. I will file the claim in court but very, very few of them actually end up going to trial. The vast majority cases are getting resolved by settlement or mediation, or even arbitration. These are short of a trial where you have a mediator who can kind of give you a sense of what the case may show. Or he may mediate between the parties and try to bring them closer together. And the vast majority of cases, over 90% are resolved that way. A small percentage end up going to trial and of

those that go to trial, the plaintiff still generally does fairly well but there's no guarantee. There's a lot of uncertainty in a jury trial and so both sides recognize that and that's why they are often resolved.

Pat: I know that many of our listeners have family members who at some point might need nursing home care or as an earlier step, might need some type of assisted living. Could you describe the difference between the assisted living setting and a nursing home?

Sean: In New York, the difference is defined by law, by statute, and I assume that's probably true in most other states. In New York, I guess the short version would be if someone needs skilled nursing care, then they would typically need to be in a nursing home. An example might be if they need medical treatments or any sort of physical therapy. They may need to be in a dementia unit. They would typically be in a nursing home whereas if they just needed some assistance with activities of daily living such as bathing or brushing their teeth or eating or getting their clothes washed, or just need some help with those activities, then they typically can be in assisted-living facility.

And another key distinction is that they have to, in an assisted living facility, they have to be able to transfer, in other words, get up from a bed into a wheelchair, from a wheelchair into the bed with minimal assistance. If they need extensive assistance such as the use of the lifts or the use of 2 aides, in New York, they wouldn't be in an assisted living facility. They would be in a nursing home.

Pat: What are the some kinds of things that give rise to litigation in an assisted-living facility?

Sean: The cases that I typically see in an assisted facility are different in many ways from a nursing home. I don't typically see bed sore cases. I do see a fair number of fall cases and often it's because they retained the resident longer than they should have. She is no longer appropriate for an assisted facility. They should have discharged her after seeing a pattern of

falls. The dementia is progressing. Then they should move her into a dementia unit which might be within the facility of the assisted-living facility or move her into a nursing home.

But falls are probably the most common reason, actually, that I see that I investigate in an assisted-living facility. I also had, as I referred to earlier, a wandering case from a dementia unit which was within the assisted-living facility. Because in New York now, by law, the assisted-living facilities are allowed to have dementia units so that the resident can age in place. They can stay within the same facility. Medication errors can occur if they're getting any assistance with their medication in an assisted-living facility.

Pat: Then they're being assisted by nurses or by aides or medication technicians?

Sean: I don't have a lot of experience with cases that involved medication errors in assisted-living facilities. Some of my colleagues have but I just haven't, I haven't experienced too many of those, so I'm not really sure.

Pat: There is a trend in some states to teach lay people how to administer medications to people and it raises all kinds of concerns about whether it's safe to have unskilled people pass pills. Do they recognize side effects? Do they understand interactions? Clearly, they don't have the knowledge to be able to do either of those things.

Sean: I can see that as a problem, absolutely and it really is just looking for ways to cut costs.

Pat: I would imagine from all the experiences that you've had that you would be able to walk into a nursing home completely unknown to you and looks for signs of either quality care or problems with care. Can you give our listeners any tips of the kinds of things that should be evaluated if you're making such an assessment?

Sean: Well, it is important to visit the facility to see if it is well maintained. I have been to facilities that from a visual standpoint appeared to be fine but when you look a little closer, you tend to get a sense of what that institution is all about. When you see residents in their wheelchairs who appear to be sedated, drooling, don't appear to be alert to what's going on and you see this throughout the halls, throughout the facility, that's often a red flag that they're under staffed. They may be improperly using psychotropic medications which we talked about earlier to sedate residents.

This is a little less common today than it was years ago or maybe even a lot less common today that it was years ago but you still see it. I still see when I walk around facilities where a lot of times the residents are in the hallways. Especially in a bigger urban areas I see that. I've seen that in New York City many, many times. I would come at different times if I was going to investigate a nursing home. I would come during the day but I also come at night because at night is when a lot of the problems develop because they're short staffed.

And they can quite frankly get away with it and often there are no visitors or few visitors, so that's important to me. I want to see what kind of activities are going on within the facility, I mean, are they actively engaging the residents in activities? Do they have an active program to engage the residents?

My son right now is volunteering in a nursing home to assist the residents with art. He is an artist and he's very impressed with the program they have there. He's actively involved in working with the residents and that's what you want to see. You want to see staff who really care about the residents, their wellbeing, and are involving in activities rather than just leaving them alone in a room and only providing the basic custodial care.

Are they taking them on the field trips? Are they taking them out of the facility? I would look into institution itself. You can tell right away when you walk in. Is it an old hospital that was converted into a nursing home

or is it a more modern institution? If it's a more modern institution, it will have certain features that be more beneficial to the residents and have less of that hospital feel to it. You know, it's supposed to a home pattern. This is where they really live. It's not supposed to be a hospital setting.

So, the more progressive facilities will have these pods or wings where the residents are in an area where they spend their entire day together. They don't have to go some large cafeteria to get their food where the staff has to transfer them from their room. In these pods they can actually get their meal right there in their room or in a small dining area with people they're familiar with. They're not to be transported somewhere else. In bigger institutions in the urban areas, you see a lot of these old hospitals that are converted to nursing homes and they have large cafeterias and have to transfer residents to be able to move them around and that costs time and money. So, I look for a more progressive facility and I would speak to family that was there.

Pat: I can see the point of that.

Sean: If they can, talk to other families to see what they think. Let them know that you're interested. That is something you can do while in the facility. There are things you can do with the Internet too that are very helpful. I don't know if you want me to talk about that.

Pat: Yeah, sure.

Sean: Before you go to the facility, I would go in a website called medicare.gov and there's a link to what we called nursing home compare which is on that website. It provides detailed information about Medicare and Medicare-certified nursing homes and they provide a star rating - just like when you go to movies, you know, it gets 5 stars or it gets 1 star. They do that with nursing homes. This is the federal government. It's going to say that it has 5 stars. It defines certain criteria and they're looking at the inspection results every year.

So, look at those results and see if they're compliant with the federal regulations. If they are, they got a higher rating. They'll look at the staffing data and staffing ratios. And if they're well-staffed, sufficiently staffed, they'll get a higher rating. So, that helps to get a sense of what you're dealing with and then you can take a look at the annual surveys by the department of health and see if there are deficiencies that were issued by the department of health - what have they found? For example, there was a high incidence of pressure sores or they failed to use measures to prevent pressure sores and your loved ones is at risk for developing pressure sores. That might just tell you that you might not want to have your loved one go there.

There's also a list of what I call the bad nursing home that the federal government publishes. Those are nursing homes that are not in compliance, so you can check that list to make sure if the places that you're going to look at are on that list.

Pat: And is this information on medicare.gov, the list of bad facilities?

Sean: I believe it is but I didn't check that before this interview but I would imagine that it is because it is maintained by federal government.

Pat: If we think about the bad nursing homes in particular, what are some of the factors that result in making that such a dangerous setting, if I can use that term, for elderly people?

Sean: I think the number 1 and number 2 would be insufficient staff and poorly trained staff. The residents are at risk because there are not enough eyes on the residents and not enough care being given to the residents to anticipate their needs. Then if the staff is poorly trained, even if there is sufficient staff, they don't know what to look for. They don't take time out to do a proper investigation. For example, you may have loved ones who are getting up in attempt to toilet themselves. As you know, nursing home residents, the elderly, will risk their lives not to soil themselves. They may be doing that with a consistent pattern of trying to

get up out of bed, trying to toilet themselves, and they're unsteady on their feet and they need help. The staff needs to anticipate that and maybe they should have them on a toileting schedule. But they have to be properly trained and have sufficient staff to identify that risk and to address that. I think those are the 2 most significant considerations - whether they're properly staffed and are they sufficiently staffed and are they properly trained.

Pat: You've got a vulnerable population that needs people who have both training as well as enough people to provide them with their needs.

Sean: That is what makes the nursing home setting so unique because that's exactly right. The nursing home residents are vulnerable; the elderly are vulnerable. They're dependent on the staff.

Pat: You and I were both in Miami earlier this year and teaching at a nursing home conference that was attended by defense attorneys. One of the speakers talked about an agreement that was used in his state that would require the family to sign a promise that they would not sue if anything went wrong in the care in the nursing home. What do you think about that type of an agreement?

Sean: We do see this from time to time and most states, I would guess that would be improper and eventually unenforceable. But that would be red flag and something that you should be concerned about in this particular facility, because they want to absolve themselves of any responsibility about anything that can happen. Under no circumstances should you sign such an agreement.

Pat: To wrap up, the last question I have for you is to think about what family members who have concerns about quality of care can do when they got a loved one in a nursing home. They may not want to file the suit and may simply want to try to get this resolved. I know we talked a little about approaching the staff in a non-adversarial manner and participating

in care planning sessions. Is there anything else that you can suggest to our listeners who are caught up in that type of the situation?

Sean: It's typically a specific fact pattern that we deal with but one of the things I do recommend is to keep a journal depending on the situation. I often talk with the family members to communicate via a journal. Try not to visit all at the same time, try to spread it out, so there's a lot of coverage.

You can communicate what issues there are and then bring those issues to the attention of the nursing staff. If you're not getting an adequate response from the nursing staff, take it to the supervisor and make sure it's documented and make sure they're aware of this particular complaint. I would communicate with all the aides as well, not just the nursing staff but the aides all the way on to the nursing supervisor.

And again, I would work with a legal nurse consultant if you want to get an expert opinion on what may be done to improve the quality of life and quality of care that your loved one is receiving.

Pat: I appreciate the time that you have spent with me this afternoon. If our listeners should want to get in touch with you, what would be the best way for them to do that?

Sean: I want to thank you for doing this opportunity. By telephone, I can be reached at the area code (5) 734-4788; or at a toll free number, it's 1-800-sdoolan which is d-o-o-l-an. By internet, my email address is sean@doolanlaw.com.

Pat: Terrific, I appreciate that information.

Sean: Thank you.